

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

**1. PLACE OF DEATH**

County.....

Registration District No. ....

Township.....

Primary Registration District No. ....

City.....

(Name) *Hannibal Bethesda Kaspa*

File No. ....

**25337**

Registered No. ....

**7142**

St. ....

Ward) ....

**2. FULL NAME**

(a) Residence, No. *Hannibal Mo* St. *16* Ward. ....

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

*female*

**4. COLOR OR RACE**

*white*

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

*married*

**6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**

*Bert Krugbaum*

**7. DATE OF BIRTH (MONTH, DAY AND YEAR)**

*Aug 22 1877*

**7. AGE**

YEARS

MONTHS

DAYS

*55*

*10*

*16*

IF LESS than 1 day, ..... hrs. or ..... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work.....

*at home*

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

*Mo*

**10. NAME OF FATHER**

*J H Pomb*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*Mo*

**12. MAIDEN NAME OF MOTHER**

*Elizabeth Mansel*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*do not know*

**14.**

INFORMANT

(Address)

*Bert Krugbaum  
Hannibal Mo*

**15.**

FILED

1928

19

*May C Standif  
REGISTRAR*

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

*July 8 1928*

**17.**

HEREBY CERTIFY, That I attended (ceased from) *6/8* ....., 19*28*, to *7/8* ....., 19*28*. that I last saw h. *er.* alive on *7/8* ....., 19*28*, and that death occurred, on the date stated above, at *7:40 P* .....

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Surgical shock following  
gill bladder disease*  
(duration) yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

*Cholera*  
(duration) yrs. mo. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

**19. DID AN OPERATION PRECEDE DEATH?**

WAS THERE AN AUTOPSY?.....

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed).....

*Marcell Chapman*

M. D.

19

(Address)

*308 Reservoir Bldg*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

**DATE OF BURIAL**

*Hannibal Mo*

*7/9 1928*

**20. UNDERTAKER**

**ADDRESS**

*A. Ellis 5240 Delmar*

K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERMANENT RECORD

