

RECORD OF CERTIFICATES OF DEATH.

Full Name of Deceased *Mary Wheeler*
PERSONAL AND STATISTICAL PARTICULARS AND MEDICAL CERTIFICATE OF DEATH.
 Sex *F* Color *W.* Age *68* Years *—* Months *—* Days *—*
 Place of Birth *Not known* (State or Country.) Lived in Illinois *Not known* Years.
 Occupation *None* Single, Married, Widower or Widow.
 Died on the *29* day of *May* 190*3*, at about *4:40* P. M.
 Place of Death *Hospital Ill* (Township, Village or City. If in City, number of Street and Ward.)
 Place of Burial *Hanksville Ill* (Cemetery.) Date of Burial *May 31*
 Name of Undertaker *David Lavery* Address *Hanksville Ill*
 Immediate Cause of Death *Exhaustion*
 Contributory Cause or Complication *Insanity*
 I hereby certify, that the above stated personal particulars are true to the best of my knowledge and belief, and that the cause of death of the above named and described deceased was as above written by me.
 Witness my hand, this *29* day of *May* 190*3* (Signature) *A. S. Graham*
 of *Hospital* Address *Hospital* (Physician, Midwife or Coroner.)
 Filed for Record this *26* day of *Oct* 190*3* *Louis Schmale Jr* County Clerk.

DURATION.			
Years.	Months.	Days.	Hours.
		<i>1</i>	<i>26</i>

Full Name of Deceased *Barbara Sauter*
PERSONAL AND STATISTICAL PARTICULARS AND MEDICAL CERTIFICATE OF DEATH.
 Sex *F* Color *W* Age *44* Years *—* Months *—* Days *—*
 Place of Birth *U. S.* (State or Country.) Lived in Illinois *Not known* Years.
 Occupation *Housewife* Single, Married, Widower or Widow.
 Died on the *18* day of *Apr* 190*3*, at about *11:30* A. M.
 Place of Death *Ill East Hospital Insane* (Township, Village or City. If in City, number of Street and Ward.) *Hospital Ill*
 Place of Burial *Dyer Ill* (Cemetery.) Date of Burial *April 19*
 Name of Undertaker *David Lavery* Address *Hanksville Ill*
 Immediate Cause of Death *Heart failure*
 Contributory Cause or Complication *Insanity*
 I hereby certify, that the above stated personal particulars are true to the best of my knowledge and belief, and that the cause of death of the above named and described deceased was as above written by me.
 Witness my hand, this *19* day of *April* 190*3* (Signature) *A. S. Graham*
 of *Hospital Ill* Address *Hospital Ill* (Physician, Midwife or Coroner.)
 Filed for Record this *26* day of *Oct* 190*3* *Louis Schmale Jr* County Clerk.

DURATION.			
Years.	Months.	Days.	Hours.
		<i>2</i>	
<i>6</i>			

Full Name of Deceased *Sophia Johnson*
PERSONAL AND STATISTICAL PARTICULARS AND MEDICAL CERTIFICATE OF DEATH.
 Sex *F* Color *W* Age *61* Years *—* Months *—* Days *—*
 Place of Birth *Sweden* (State or Country.) Lived in Illinois *Not known* Years.
 Occupation *Housewife* Single, Married, Widower or Widow.
 Died on the *Just* day of *April* 190*3*, at about *7:00* P. M.
 Place of Death *Ill Eastern Hospital Insane* (Township, Village or City. If in City, number of Street and Ward.) *Hospital Ill*
 Place of Burial *Hospital Ill* (Cemetery.) Date of Burial *April 4*
 Name of Undertaker *Hospital Authorities* Address *Hospital Ill*
 Immediate Cause of Death *Prostration*
 Contributory Cause or Complication *Insanity*
 I hereby certify, that the above stated personal particulars are true to the best of my knowledge and belief, and that the cause of death of the above named and described deceased was as above written by me.
 Witness my hand, this *1st* day of *April* 190*3* (Signature) *A. S. Graham*
 of *Hospital Ill* Address *Hospital Ill* (Physician, Midwife or Coroner.)
 Filed for Record this *26* day of *Oct* 190*3* *Louis Schmale Jr* County Clerk.

DURATION.			
Years.	Months.	Days.	Hours.
		<i>2</i>	
<i>30</i>			