

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 7353

Registration District No. 547

Primary Registration District No. 3079

Registrar's No. 40

1. PLACE OF DEATH:  
 (a) County Marion  
 (b) City or town Hannibal  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
904 Baker St. ✓  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Marion  
 (c) City or town Hannibal, MO  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 904 Baker  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Margaret Sullivan 415  
 3. (b) If veteran, name war L  
 3. (c) Social Security No. ✓

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Jan. day 28  
 year 1940 hour 8:40 minute \_\_\_\_\_ a. M.

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife Ray 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to Jan 28, 1940  
 that I last saw h. in the home on Jan 28 and that death occurred on the date and hour stated above.

7. Birth date of deceased Oct. 11 1859  
 (Month) (Day) (Year)  
 8. AGE: Years 80 Months 3 Days 17  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death  
Myocardial infarction  
 Due to arteriosclerosis  
 Due to arteriosclerosis

9. Birthplace \_\_\_\_\_ (City, town, or county) Ireland (State or foreign country)  
 10. Usual occupation Retired

Other conditions Cholesterol  
 (include pregnancy within 3 months of death)  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy none 54

11. Industry or business \_\_\_\_\_  
 MOTHER FATHER { 12. Name UNKNOWN 7  
 13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
 14. Maiden name UNKNOWN 9  
 15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

16. (a) Informant's own signature Paul Sullivan  
 (b) Address 904 Baker, Hannibal, Mo  
 17. (a) St Marys (b) Date thereof Jan. 31, 40  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation St Marys  
 18. (a) Signature of funeral director James O'Donnell  
 (b) Address Hannibal, Mo  
 19. (a) 2-2-40 (b) St. C. Fisher  
 (Date received local registrar) (Registrar's signature)

23. Signature John Fisher (M.D. or other) \_\_\_\_\_  
 Address 107 1/2 Broadway, Hannibal, Mo

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. 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.

Rev. 5-17-39  
 I 111851

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Michael J. O'Connell*

Licensed Embalmer No. *3246*

P. O. Address *Hannibal Mo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**