

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

167-6-17-39  
I X1951

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 7358

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 57

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: 1104 North St v  
(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  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1104 North St.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

3. (a) PRINT FULL NAME Anna B. Brooks

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Wm. P. Brooks 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Springfield, Mo  
(Month) 3 (Day) 16 (Year) 1893

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>1</u>	<u>26</u>	hr. _____ min. _____

9. Birthplace Springfield Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Wm. Fry

13. Birthplace Ill.  
(City, town, or county) (State or foreign country)

14. Maiden name Helen Fry

15. Birthplace Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Bertha Robert

(b) Address 1104 North St

17. (a) Burial (b) Date thereof Feb. 14 - 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly, Missouri

18. (a) Signature of funeral director Geo E. Roberts

(b) Address Hannibal

19. (a) Feb. 14, 1940 (b) W. J. Fisher  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 11  
 year 1940 hour 1 PM minute 45 M.

21. I hereby certify that I attended the deceased from Oct 5, 1940 to Oct 11, 1940;  
 that I last saw her alive on Oct 11, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death White Suffocation  
 Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to Senility

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically

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

23. Signature W. J. Fisher (M. D. or other) \_\_\_\_\_

Address Hannibal, Mo Date signed 2/14/40

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**