

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **11680**

Registration District No. **547**

Primary Registration District No. **3029**

Registrar's No. **123**

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:
St. Elizabeth Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
 (Specify whether

In this community _____
 years, months or days) 15th May

3. (a) PRINT FULL NAME Ethel Pappan
 3. (b) If veteran, name war _____ No. _____
 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife Nicholas 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased April 13 1886
 (Month) (Day) (Year)

8. AGE: Years 53 Months 11 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis (City, town, or county) Mo (State or foreign country)

10. Usual occupation House Wif

11. Industry or business _____

MOTHER FATHER
 12. Name John A. Peters
 13. Birthplace Ill (City, town, or county) (State or foreign country)
 14. Maiden name Mary Leighton
 15. Birthplace Ind (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Nicholas Pappan
 (b) Address Quincy St

17. (a) Removal (b) Date thereof _____ (Month) (Day) (Year)
 (Specify cremation, or removal)

(c) Place: burial or cremation St. Louis Mo

18. (a) Signature of funeral director Jas. O'Donnell
 (b) Address Hannibal Mo

19. (a) Apr 10-40 (b) St. L. Fishel
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town Clayton
 (If outside the city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10
 year 1940 hour 12 minute 20 PM

21. I hereby certify that I attended the deceased from Apr 8-40
April, 1940, to Apr 10, 1940
 that I last saw her alive on Apr 10, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Trauma
Fracture of femur & tibia
& rib

Due to _____
 Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident
 (b) Date of occurrence Apr 8-40
 (c) Where did injury occur? Highway, New Land
 (City or town) (County) (State)
 (d) Did injury occur, in or about home, on farm, in industrial place, in public place?
Highway auto
 While at work? No (Specify type of place) (e) Means of injury auto

23. Signature J. M. ... (M. D. or other)
 Address Hannibal Mo Date signed Apr 10

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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

Rev. 5-17-39
 I X 9381

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.

710 002

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 Harold O'Donnell

Licensed Embalmer No. 3889

P. O. Address Hammond 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 11680

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 123

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

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Ethel Pappan

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nicholas Pappan 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 33 Months 11 Days 27 If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) May 10, 1940 (b) E. M. Rucke (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month apr day 10 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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 J. M. Franck (M. D. or other)

Address Hannibal State signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

Registration District No. 347

Primary Registration District No. 3029

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Harrison
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(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)

3. (a) PRINT FULL NAME Elhel Pappan

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 53 Months 11 Days 27 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month apr day 10 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral fracture of left femur & left tibia

Due to _____

Due to # M. M. Q #

Other conditions _____ (include pregnancy within 3 months of death)

Major findings: 2:10 m
Of operations 98

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 Auto

23. Signature F. M. Francka (M. D. or other) _____
Address Harrison _____ Date signed _____

SUPPLEMENTARY