

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15452

MAY 13 1940
Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 129

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: Levering Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether years, months or days) 1 day

3. (a) PRINT FULL NAME Loretta Jean Margriter

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

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

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

7. Birth date of deceased December 14, 1939
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
		<u>3</u>	<u>27</u>	hr. _____ min.

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

10. Usual occupation XX

11. Industry or business XX

MOTHER FATHER { 12. Name Arthur E. Margriter

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

14. Maiden name Margaret Shoe

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

16. (a) Informant's own signature Ruth E. Margriter

(b) Address 520 Winter

17. (a) Burial (b) Date thereof 4/12/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet

18. (a) Signature of funeral director Wm M Smith

(b) Address 902 Broadway Hannibal

19. (a) 4-13-40 (b) W C Fisher
(Date received local registrar) (Registrar's signature)

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. 520 Winter
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11
year 1940 hour 9:00 minute _____ A. 11 M.

21. I hereby certify that I attended the deceased from April 11, 1940, to April 11, 1940
that I last saw her alive on 9 AM 4/11, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Meningococci septicemia Duration 16 hours

Due to Presence of Meningococci in the blood stream

Due to _____
Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy No autopsy but a post mortem blood culture was made

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? Yes

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Charles B. Lanham, M.D. or other
Address B & 1/2 City Hannibal, Mo Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically

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.

WHILE I REMAIN—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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..... *Joseph J. Marsh*.....
Licensed Embalmer No..... **3932**.....

P. O. Address..... **Hannibal Missouri**.....

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.