

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18970
Registrar's No. 140

Registration District No. 547

Primary Registration District No. 3029

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Hannibal, Mo.
(c) Name of hospital or institution St Elizabeth Hospital
(d) Length of stay: In hospital or institution 4-25-40 to 9-30-40
In this community 5 Days

3. (a) PRINT FULL NAME Minnie Linae 520
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife WILLIAM GAINES
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased Jan 12 1870

8. AGE: Years 70 Months 18 Days ✓ If less than one day hr. ✓ min. ✓

9. Birthplace Marion Co. Mo.

10. Usual occupation Housework

11. Industry or business ✓

MOTHER FATHER { 12. Name Samuel Mallory
18. Birthplace Unknown

MOTHER FATHER { 14. Maiden name Elizabeth Stephens
15. Birthplace Unknown

16. (a) Informant's own signature W. G. Gaines

(b) Address Marion, Mo.

17. (a) Burial (b) Date thereof 5-2-1940

(c) Place: burial or cremation ash, Mo.

18. (a) Signature of funeral director Spotts Blakely

(b) Address Paris, Mo.

19. (a) May 1, 1940 (b) W. G. Fisher

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Marion
(c) City or town Rural
(d) Street No. North West Madison
(e) If foreign born, how long in U. S. A. ✓ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30
year 1940 hour 2:20 minute ✓ P. M.
21. I hereby certify that I attended the deceased from 1940, 1970, to 1940, 1970,
that I last saw her alive on 1970 and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes mellitus
Chromyphoria
Due to 54

Duration
?
?

Other conditions Chromyphoria
(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) (a) Means of injury
23. Signature J. H. Fisher (M. D. or other) ✓
Address Paris, Mo. Date signed 5-2-40

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 E. H. Agnew

Licensed Embalmer No. 4000

P. O. Address Parise, 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.