

Registration District No. 547

Primary Registration District No. 3079

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: Windsor Hotel  
(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. Windsor Hotel Main St  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2nd  
year 1940 hour 7:15 minute P M.  
21. I hereby certify that I attended the deceased from March 20  
\_\_\_\_\_, 1940, to May 2, 1940;  
that I last saw her alive on May 2, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of left lung  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions: Left lobar pneumonia  
Diabetes Mellitus  
(Include pregnancy within 3 months of death)

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

Major findings:  
Of operations: None  
Of autopsy: None

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? 400  
\_\_\_\_\_, \_\_\_\_\_ (Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature Bernard T. Murphy (M. D. or other) \_\_\_\_\_  
Address Hannibal Mo Date signed 5-10-40

3. (a) PRINT FULL NAME Elizabeth R. Kempinsky

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 Married

6. (b) Name of husband or wife Ellsworth 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Oct 14, 1867  
(Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days 18 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation House wife

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

12. Name Thomas Rosser

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

14. Maiden name Guenevere Roland

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

16. (a) Informant Ellsworth Kempinsky

(b) Address Windsor Hotel Hannibal, Mo

17. (a) Burial (b) Date thereof May 5, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wellsville, Mo

18. (a) Signature of funeral director James O. Russell  
(b) Address Hannibal, Mo

19. (a) May 10, 1940 (b) St. C. Fisher  
(Date received by registrar) (Registrar's signature)

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

64  
1  
5

2  
39  
-31-39  
X21492

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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. Hance

Licensed Embalmer No. 2244

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18982

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Madison  
(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)

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.

3. (a) PRINT FULL NAME Elizabeth R. Kempinsky

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 m

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

7. Birth date of deceased Oct-14-1867  
(Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

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

MOTHER FATHER { 12. Name \_\_\_\_\_

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

14. Maiden name Elizabeth Poland

15. Birthplace South Wales (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) July 5 40 E. M. Lude  
(To be received local registrar) (Registrar's signature)

DECEASED CERTIFICATION

20. DATE OF DEATH Month May day 2d  
year \_\_\_\_\_ 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 \_\_\_\_\_

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 Bernard H. Murphy M.D. (Other)

Address Hannibal Mo Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

S-18982