

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18985

Registration District No. 547

Primary Registration District No. 3079

Registrar's No. 146

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:
Residence 418 N 6th
(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) Life

3. (a) PRINT FULL NAME Alice Helm Logan 250

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 Widowed

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

7. Birth date of deceased March 28 1862
(Month) (Day) (Year)

8. AGE: Years 78 Months 1 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____

12. Name Cyrus T. Helm

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

14. Maiden name Katherine Park

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

16. (a) Informant's own signature Walter Logan

(b) Address Hannibal Missouri

17. (a) Burial (b) Date thereof May 10 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Crawford Smith
(b) Address 902 Broadway Hannibal

19. (a) 5/9/40 (b) W. E. 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. 418 North Sixth
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8
year 1940 hour 7 minute 25 P. M.

21. I hereby certify that I attended the deceased from 4-19, 1940, to 5-8, 1940
that I last saw her alive on 5-5-40, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis Duration 19 days

Due to Arterio Sclerosis

Due to _____

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

Major findings:
Of operations no

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) no

(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? no

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

23. Signature Walter Logan (M. D. or other) _____
Address Hannibal Mo Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically

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. *J. 3932 rsh*

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.