

SEP 23 1940 547
Registration District No.

Primary Registration District No. **3079**

Registrar's No. **249**

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 8 Hours
(Specify whether
In this community Yes
years, months or days)

8. (a) PRINT FULL NAME EDRIG E. HUMKE

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 MARRIED

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

7. Birth date of deceased. JAN 20 1897
(Month) (Day) (Year)

8. AGE: Years 43 Months 7 Days 4 If less than one day hr. min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business

12. Name GEORGE HOFFMAN

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

14. Maiden name JAN PURPUS

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

16. (a) Informant George Hoffman

(b) Address Quincy Ill

17. (a) BURIAL (b) Date thereof 8. 27 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NEAR COUNTRYSIDE ILL. LAST PRARIE CHURCH

18. (a) Signature of funeral director JAMES O'DONNELL

(b) Address HANNIBAL, MO

19. (a) Aug 26 40 (b) J. C. HESHER
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MARION
(c) City or town HANNIBAL MO.
(If outside city or town limits, write "RURAL")
(d) Street No. 212 CYPRESS ST.
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 24 day aug.
year 1940 hour 11 minute 57 P.M.

21. I hereby certify that I attended the deceased from August 23rd 1940 to August 24th 1940
that I last saw her alive on August 24th 1940
and that death occurred on the date and hour stated above.

Immediate cause of death acute nephritis Duration not known

Due to Possible search to breast abscess.

Due to _____

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

Major findings: No operations

Of operations _____

Of autopsy No 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)

23. Signature J. C. HESHER (M. D. or other)

Address HANNIBAL MO Date signed 8/26/40

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

124A

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

Ralph W. Clark

Registered Apprentice No. *242*

working under my personal supervision.

Signed

Michael J. O'Donnell

Licensed Embalmer No. *3246*

P. O. Address

Hennepin Ave

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. **29065**

Registration District No. **547**

Primary Registration District No. **3029**

Registrar's No. **249**

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

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.....
years, months or days)

3. (a) PRINT FULL NAME **Edria E. Humke**

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..... (Month) (Day) (Year)

8. AGE: Years **43** Months **7** Days **4** 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..... (City, town, or county) (State or foreign country)

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)..... (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.

20. DATE OF DEATH: Month **Aug** day **24** year **1990** 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 **acute nephritis**
possible sequelae to breast abscess

Due to **not known**

Other conditions **two pneumoniae**
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy..... **190**

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..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTAL

PHYSICIAN

Underline the cause to which death should be charged statistically.

