

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.

FILED OCT 18 1940

State File No. _____

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 265

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: 412 South Section
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Not in hospital
(Specify whether years, months or days) 76 years

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. 412 South Section
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME: James Shannon Michaels

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

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

6. (b) Name of husband or wife Hannie C. Michaels 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased December 4, 1858
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>9</u>	<u>—</u>	hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business _____

12. Name Jacob Michaels

13. Birthplace Not known
(City, town, or county) (State or foreign country)

14. Maiden name Pauline (Does not know)

15. Birthplace Not known
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature James S. Michaels

(b) Address Hannibal, Missouri

17. (a) Burial (b) Date thereof Sept. 6, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grandview Cemetery

18. (a) Signature of funeral director Ray P. Schwartz

(b) Address Hannibal, Missouri

19. (a) Sept. 7, 1940 (b) J. C. Fisher
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September, day 4th, year 1940 hour 12:45 minute 0 P. M.

21. I hereby certify that I attended the deceased from Sept 1st, 1940, to Sept 4th, 1940, that I last saw him alive on Sept 4th, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Acute gastritis
Due to Ford

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

Major findings: Of operations _____
Of autopsy _____

Duration _____
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? Yes

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

23. Signature Fredrick B. Lencer (M. D. or other) _____

Address Hannibal, Mo Date signed 9/7/40

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.....

Ray P. Schwartz....., Registered Apprentice No.....
working under my personal supervision.

Signed *Ray P. Schwartz*.....

Licensed Embalmer No. *1768*

P. O. Address. *Wannibal, 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.