

S. No. 2
11-10-39
5-17-39
482

DEPARTMENT OF COMMERCE
BUREAU OF THE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35802

State File No. _____

Registration District No. 547

Primary Registration District No. 3079

Registrar's No. 293

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Hannibal Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1241 Lyon St. 2.
(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. 1241 Lyon St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 4
year 1940 hour 11 p. minute _____ M.

21. I hereby certify that I attended the deceased from June 14 - 20, 1940 to Oct 4, 1940.
that I last saw her alive on Oct 4, 1940.
and that death occurred on the date and hour stated above.

Immediate cause of death Metastatic Malignancy Duration about 4 yrs.
Liver - primary focus not determined
Due to Verified by Exploratory
Lapar.

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

Major findings: Metastatic Malignancy
Of operations Liver.
Of autopsy _____
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? O.

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature J. E. Sultman, M.D. (M. D. or other)
Address Hannibal, Mo. Date signed 10/3/40

3. (a) PRINT FULL NAME Katie Ryce

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

4. Sex Female 5. Color or race White 6. (e) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased June 29 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 3 5 hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name James Grady

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

14. Maiden name Artimissa Perry

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

16. (a) Informant Mrs. Raymond Mosley
(b) Address 1241 Lyon St.

17. (a) Burial (b) Date thereof Oct. 6, 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation River View, Louisiana
18. (a) Signature of funeral director James Donnell
(b) Address Hannibal, Mo.
19. (a) Oct. 9 - 40 (b) W. C. Gisher
(Date received local registrar) (Registrar's signature)

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

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

Harold O'Donnell

Licensed Embalmer No.

3889

P. O. Address

Hamilton 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.