

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.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

FILED FEB 17 1941

3402

1. PLACE OF DEATH

County Marion Registration District No. 547  
Township Mason Primary Registration District No. 3029  
City Hannibal (No. 209 South Locust St. 1)

File No. \_\_\_\_\_  
Registered No. 2664 (Ward 1)

2. FULL NAME Fannie L. English Thrasher

(a) Residence, No. 209 South Locust St., \_\_\_\_\_ Ward. 0  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joel F. Thrasher

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 12, 1941  
22. I HEREBY CERTIFY, That I attended deceased from Dec - 1, 1940 to Jan 12, 1941  
I last saw her alive on Jan 11, 1941. Death is said to have occurred on the date stated above, at 11:30 P.M.  
The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) February 22, 1864  
7. AGE YEARS 76 MONTHS 10 DAYS 20  
If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

Myocarditis Date of onset ?

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Own Home  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

Other contributory causes of importance: Hemiplegia 2 months

12. BIRTHPLACE (CITY OR TOWN) Lewis County (STATE OR COUNTRY) Missouri

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? N

13. NAME Woodford English  
14. BIRTHPLACE (CITY OR TOWN) Culpeper (STATE OR COUNTRY) Virginia

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

15. MAIDEN NAME Sarah Tate  
16. BIRTHPLACE (CITY OR TOWN) Fauquier County (STATE OR COUNTRY) Virginia

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

17. INFORMANT Mrs R. L. Clarkson (ADDRESS) 130 N. Republic St.

24. Was disease or injury in any way related to occupation of deceased? NO  
If so, specify \_\_\_\_\_  
(Signed) W. C. Fisher O. M. D.  
(Address) Hannibal Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Grandview, Hannibal DATE 1/15/41  
19. UNDERTAKER W. C. Fisher (ADDRESS) 902 Broadway

20. FILED Jan. 15, 1941 W. C. Fisher Registrar.

93.4

This body was embalmed by *James A. Moles*

License Number 3296

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
EMERALD CITY  
EMERALD CITY

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 3402

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 Marión

(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 \_\_\_\_\_)

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 Fannie L. English Theaker

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month Jan day 12  
year 1999 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.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased: \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

Immediate cause of death myocarditis

8. AGE: Years 76 Months 10 Days 20  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_

Due to Hemiplegia  
Due to Hypertension

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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 \_\_\_\_\_

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

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 [Signature] (M. D. or other) \_\_\_\_\_  
Address Hannibal, Mo. Date signed 4-11-41

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

SUPPLEMENTARY

