

MAR 19 1941

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

7568
Do not use this space.

1. PLACE OF DEATH

(a) County Marion Registration District No. 547
 (b) Township Marion Primary Registration District No. 3029 64
 or City Hannibal (c) Street No. 607 N 4th Registered No. 47
 (d) (If death occurred in Hospital or Institution, write its name instead of street and number) St. 2
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lella L. Sagarney

(a) Residence, No. 607 North 4th St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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 Joseph
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 8 1878
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin. 62 2 18
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House work
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Data deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hannibal Ill.

MOTHER FATHER 13. NAME Joseph White

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Ruth Kirk

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Ray W. Speman St. Louis Mo.

18. BURIAL, CREMATION OR REMOVAL PLACE Grand View Burial Park DATE 2/7/41

19. FUNERAL DIRECTOR (NAME) (ADDRESS) James H. Howell Hannibal Mo.

20. FILED 2-8-41 St. C. Crisher Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-5-41 1941

22. I HEREBY CERTIFY, That I attended deceased from FEB 1 1941, to FEB 5 1941

I last saw him alive on FEB 5 1941 Death is said to have occurred on the date stated above, at 6:55 a.m.

The principal cause of death and related causes of importance were as follows:

Myocardial Degeneration
 Other contributory causes of importance: 92.5
Unstable Heart trouble since

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

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.

Manner of injury Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify (Signed) GG Salyer, M. D.

(Address) Hannibal Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

1 X 16603

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 *W. H. O'Connell*
Licensed Embalmer No. *3889*
P. O. Address *Hannibal 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 7568

Registration District No. 549

Primary Registration District No. 3029

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
LUCIENA 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..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Della L. Sapbury

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

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 Nov - 8 - 1878
(Month) (Day) (Year)

8. AGE: Years 62 Months 2 Days 48 27 min.
If less than one day

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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)

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) 6/19/41 (b) E. M. Luckey
(Date received local registrar) (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 2 day 5
year 1941 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.....

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

Major findings:
Of operations.....
Of autopsy.....

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 E. E. Salinger (M. D. or other)
Address Hannibal signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

