

FILED MAY 21 1941

STANDARD CERTIFICATE OF DEATH

State File No. 15165

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 123

1. PLACE OF DEATH:
 (a) County Marion
 (b) City or town Hannibal
 (c) Name of hospital or institution 205 Shepherd Pl. Residence
 (d) Length of stay: In hospital or institution _____
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME Robert William Currier
 3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Beulah 6. (c) Age of husband or wife if alive 45 years
 7. Birth date of deceased June 10, 1893
 (Month) (Day) (Year)

8. AGE: Years 47 Months 9 Days 25 If less than one day hr. min.

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

10. Usual occupation Merchant
 11. Industry or business Shoe

MOTHER FATHER
 12. Name John Robert Currier
 13. Birthplace Quincy Illinois
 14. Maiden name Minnie Crew
 15. Birthplace Quincy Illinois

16. (a) Informant Mrs R. W. Currier
 (b) Address 205 Shepherd Place

17. (a) Burial (b) Date thereof April 9, 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mount Olivet

18. (a) Signature of funeral director Wm. M. Smith
 (b) Address 902 Broadway Hannibal

19. (a) April 10, 1941 (b) W. C. Fisher
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Marion 64
 (c) City or town Hannibal 3
 (d) Street No. 205 Shepherd Place 4
 (e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5
 year 1941 hour 11 minute P.M. M.
 21. I hereby certify that I attended the deceased from Oct. 1940
4-5, 1941;
 that I last saw him alive on 4-5, 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute cardiac failure (with acute pulmonary edema)
 Due to Hypertension - left hemiplegia
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____

Duration 20 months
1 year 6 mos
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

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? _____
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
490 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____
 23. Signature Harold Sudick (M. D. or other) AMS
 Address Hannibal Mo Date signed 4-7-41

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

92 D

Public Health Department

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 James A. Moles
Licensed Embalmer No. 3296

P. O. Address Hannibal Missouri

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12765-

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. _____

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

4. Sex m 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 _____ year _____

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 47 Months 9 Days 25 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 _____ (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) _____ (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) Citizen of foreign country _____ (Yes or No).
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: month Apr day 5
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death acute Cardiac failure Duration _____
(with acute Pulmonary edema)
Due to hypertension

Due to Left Hemiplegia
Other conditions N.M.D.
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of 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) _____
of Means of injury _____

23. Signature Howard Sudeal (M. D. or other) M.D.

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

