

10. 2
13-4
17-3
x
3
4

FILED JUL 17 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22170

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 190

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:
St. Elizabeth Hospital
(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. 1506 Broadway
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Julia E Lavoo

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

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

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

7. Birth date of deceased December 12 1869
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>71</u>	<u>6</u>	<u>2</u>	_____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Peter Lavoo

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

14. Maiden name Mary Hunold

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

16. (a) Informant Mrs. Frank McIntyre
(b) Address Hannibal Mo

17. (a) Burial (b) Date thereof 6 18 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery
(d) Signature of funeral director James O'Donnell
(e) Address Hannibal Missouri

19. (a) June 16 1941 (b) W. C. Fisher
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14
year 1941 hour 9:15 p. M. minute _____ M.

21. I hereby certify that I attended the deceased from June 12, 1941, to June 14, 1941;

that I last saw her alive on June 14, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis.

Due to Asthma

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 B. S. Murphy (M. D. or other) _____
Address Hannibal, Mo Date signed 6-16-41

Duration

Unknown

Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Aug 19 1941

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 C. Marshall*

Licensed Embalmer No. *3889*

P. O. Address *Harwood 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. _____

1. PLACE OF DEATH: Marion

(a) County _____

(b) City or town _____

(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution _____
(If not in hospital or institution, write street number or location) (Specify whether)

In this community _____
years, months or days

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 _____

3. (a) PRINT FULL NAME Julia E. Laroo

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex _____

5. Color or race _____

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ year _____ min.

7. Birth date of deceased Dec 12 1869
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____
If less than one day _____ min.

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

10. Usual occupation Housework

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) Aug 20 41 (b) Ethel L. Looch
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14
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 _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTAL

