

Registration District No. **577**

Primary Registration District No. **3029**

Registrar's No. **295**

1. PLACE OF DEATH:

(a) County **Marion**
(b) City or town **Harrison**
(c) Name of hospital or institution **St Elizabeth's Hosp.**
(d) Length of stay: In hospital or institution **1 week**
In this community **1 week**
years, months or days

3. (a) PRINT FULL NAME **Lucille M. Chance**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow 2**

6. (b) Name of husband or wife **Harry** 6. (c) Age of husband or wife if alive **2** years

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

8. AGE: Years **49** Months Days If less than one day hr. min.

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

10. Usual occupation **Nurs. W.P.A.**

11. Industry or business

MOTHER FATHER { 12. Name **Michael O'Connor**
13. Birthplace (City, town, or county) (State or foreign country) **ILL**
14. Maiden name **Laura Gillette**
15. Birthplace (City, town, or county) (State or foreign country) **ILL**

16. (a) Informant **Henry O'Connor**
(b) Address **Harrison, MO**

17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **Oct. 31-1941** (Month) (Day) (Year)
(c) Place: burial or cremation **Brookfield, MO**

18. (a) Signature of funeral director **James O'Connor**
(b) Address **Harrison, MO**

19. (a) **11-7-41** (Date received local registrar) (b) **W. C. Fisher** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Linn 58**
(c) City or town **Brookfield**
(d) Street No. **4553 Sedgewick**
(e) Citizen of foreign country? (Yes or No) **1**
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **30** year **1941** hour minute **3:57 P.M.**

21. I hereby certify that I attended the deceased from **October 23** 1941 to **October 30** 1941, that I last saw her alive on **Oct. 30** 1941, and that death occurred on the date and hour stated above.

Immediate cause of death **Tuber pneumonia**

Due to **Carcinoma of cervix with metastasis**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **H&A**
Of autopsy **no**

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 **J. Murphy** (M.D.)
Address **Harrison, MO** Date signed **11-7-41**

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

64
3
4

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.....

Franklin, 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

State File No. 35502

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)

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

Lucille M. Cerance

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 W

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

7. Birth date of deceased Nov 10 1891
(Month) (Day) (Year)

8. AGE: Years 49.54 Months _____ Days _____ If less than one day _____ 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 _____

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) Dec 12-41 (b) Em Lucille
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October Day _____ Year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____ (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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

S-35502