

96

FILED MAY 25 1942

Registration District No.

Primary Registration District No.

3029

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: 419 North Section  
(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. 419 North Section  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9  
 year 1942 hour 11 minute 15 P. M.

21. I hereby certify that I attended the deceased from Jan - 1940 to apr 9 1942  
 that I last saw her alive on apr 2 1942  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Metastatic Carcinoma 2 yrs

Due to: Carcinoma of Cervix Site not 2 yrs

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

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

Major findings: as above 46 f

Of operations: \_\_\_\_\_

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

Duration

2 yrs

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)  
 (r) Means of injury \_\_\_\_\_

23. Signature M. H. ... (M. D. or N. D.)  
 Address Hannibal Mo Date signed 4/12/42

3. (a) PRINT FULL NAME Leona Estelle Barr Pulliam

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 Married

6. (b) Name of husband or wife Otho Grant Pulliam 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased June 16, 1878  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>63</u>	<u>9</u>	<u>23</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Francis Andrew Barr

13. Birthplace Breckenridge County Kentucky  
(City, town, or county) (State or foreign country)

14. Maiden name Amanda Rebecca Johnson

15. Birthplace Marion County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Otho G. Pulliam

(b) Address 419 North Section

17. (a) Burial (b) Date thereof 4/12/42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grandview Burial Park

18. (a) Signature of funeral director [Signature]

(b) Address 902 Broadway Hannibal

19. (a) 4/12/42 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

1146

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

MOTHER FATHER

11-42

**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. 14929

Registration District No. 3-49

Primary Registration District No. 3029

Registrar's No.

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Marion  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
W. H. ...  
(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 MO (b) County Marion  
(c) City or town Marion  
(If outside city or town limits, write "RURAL")  
(d) Street No. 419 North Section  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Leona E. D. Pulliam

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 m

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

7. Birth date of deceased June 16-18  
(Month) (Day) (Year)

8. AGE: Years 63 Months 9 Days 13 If less than one day \_\_\_\_\_ min.

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address \_\_\_\_\_  
19. (a) 4/12/42 (b) Robert Connor  
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day \_\_\_\_\_  
Year 1942 Hour 11 minute 15 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_  
that I have seen him/her 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 \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

