

FILED DEC 17 1942

Registrar's No. 265Registration District No. 209Primary Registration District No. 3043

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:
Levering 0
 (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 Mary R. Comstock

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, widowed 2
 6. (b) Name of husband or wife Charles J. Comstock 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased August 18, 1864
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 2 11 hr. min.

9. Birthplace Louisville Kentucky (City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business.....

12. Name Dr. Wiley Rogers
 13. Birthplace Louisville Kentucky (City, town, or county) (State or foreign country)
 14. Maiden name Eugenia Lloyd
 15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Charles Comstock Jr.(b) Address 711 A Broadway17. (a) Burial (b) Date thereof 10/30/42
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Cave Hill Cemetery
 (City, town, or county) (State or foreign country)18. (a) Signature of funeral director Wm. M. Smith Louisville Kentucky
 (Specify type of place)(b) Address 902 Broadway Hannibal19. (a) 10/29/42 (b) R. W. Connor
 (Date received local registrar) (Registrar's signature)

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. 711 A Broadway
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country..... 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 29
 year 1942 hour 12 minute 05 A. M.21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;
 that I last saw her alive on Oct 29, 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
Branchial pneumonia
 Due to Chronic myocarditis
 Due to.....

Other conditions Fractured Right Hip
 (Include pregnancy within 3 months of death)
about 2 months previous

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)..... 119
 (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?..... (e) Means of injury..... 023. Signature R. W. Connor (M. D. or other) MD
 Address Hannibal Mo Date signed 10-29-42

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.....

Wm M Smith

Licensed Embalmer No. 1204

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. 41278
Registrar's No. 265

Registration District No. 209

Primary Registration District No. 3043

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

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 Mary R. Comstock

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.....

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

7. Birth date of deceased Aug 18
(Month) (Day) (Year)

8. AGE: Years 78 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)..... (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 Oct Day 9
year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
that I first saw him..... alive on....., 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocardiitis Duration.....
bronchial pneumonia

Due to.....

Due to.....

Other conditions Fracture of right hip
(Include pregnancy within 3 months of death) about 2 mos previous

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 Oct. 5-1942

(c) Where did injury occur? Hannibal, Marion, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In home

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

23. Signature Dr. Murphy (M. D. or other).....

Address Hannibal - Mo. Date signed 2-1-43

SUPPLEMENTARY

