

FILED APR 25 1943

Registration District No. 207

Primary Registration District No. 3043

State File No. _____

Registrar's No. 63

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Harrison
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
O Leveering Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 5 yrs (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Marion
(c) City or town Harrison
(If outside city or town limits, write "RURAL")
(d) Street No. 310 Mark Twain
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Shirley Jane Dert
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 Divorced
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb 6 1943
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Samuel Dert
13. Birthplace _____ MO
(City, town, or county) (State or foreign country)
14. Maiden name Virginia Jones
15. Birthplace _____ Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Sam. Kent
(b) Address 310 Mark Twain Harrison Mo
17. (a) Burial (b) Date thereof 2-25-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Riverside Cem.

18. (a) Signature of funeral director James O'Connell
(b) Address Harrison Mo
19. (a) 3-2-43 (b) R. H. Connor
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 24
year 1943 hour _____ minute 3 a M.
21. I hereby certify that I attended the deceased from Feb 6
1943, to Feb. 24 1943
that I last saw him alive on Feb. 24 1943
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Bronchial pneumonia ✓
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 B. L. Murphy (M. D. or other)
Address Harrison Mo Date signed 3-1-43

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

1146

(Licensed Embalmer's Statement on Reverse Side)

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 Michael J. O'Connell

Licensed Embalmer No. 2246

P. O. Address Hannibal Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. 14853
Registrar's No. 63

Registration District No. 209

Primary 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 Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 da. (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Shirley G. Went

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 5

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

7. Birth date of deceased Feb. 6 (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 _____

11. Industry of 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(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 Mo. (b) County Marion
(c) City or town Hannibal (If outside city or town limits, write "RURAL")
(d) Street No. 310 Mark Twain (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. Day 24 Year 1943 Hour _____ Minute _____ M.

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

Bronchial Pneumonia

Due to Patent Foramen ovale

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations 157e

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 B. L. Murphy (M. D. or other) _____

Address Hannibal, Mo. Date signed 5-28-43

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

SUPPLEMENTARY

S-14853