

FILED DEC 17 1943

Registration District No. 204

Primary Registration District No. 3043

Registrar's No. 306

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:  
911 Wabash St. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion <sup>64</sup>  
(c) City or town Hannibal <sup>3</sup>  
(If outside city or town limits, write "RURAL")  
(d) Street No. 911 Wabash ave <sup>7</sup>  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12 1943  
year 1943 hour \_\_\_\_\_ minute 8:35  
21. I hereby certify that I attended the deceased from Oct 11-43  
1943 to Oct 12 1943  
that I last saw him alive on Oct 11 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Bright's Disease  Duration  
& Chronic Myocarditis

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

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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?  
\_\_\_\_\_ (Specify type of place)

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature J.P. Darney (M. D. or other) M.D.  
Address Hannibal Mo Date signed Oct 15-43

3. (a) PRINT FULL NAME OTTO O. OLTMAN

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

4. Sex MALE 5. Color or Race Wh. It. 6. (a) Single, widowed, married, divorced Wid.

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

7. Birth date of deceased: May 10 1865  
(Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Walterman

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 Mr Edward Oltman

(b) Address Hannibal Mo

17. (a) Burial (b) Date thereof 10-14-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. J. Plevier Cemetery

18. (a) Signature of funeral director James O'Donoghue  
(b) Address Hannibal

19. (a) 10-15-43 (b) R.W. Connor  
(Data received local registrar) (Registrar's signature)

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

11  
1-39  
X25390

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.....

*Michael J. O'Rourke*

Licensed Embalmer No. *3246*

P. O. Address.....

*Hennibal 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.**

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 Hammel  
(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) (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME otto o. Altman

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

4. Sex M 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..... year

7. Birth date of deceased may 10 1924  
(Month) (Day) (Year)

8. AGE: Years 78 Months 6 Days 24 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

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

(b) Address

19. (a) (Date received local registrar) (b) (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 12 year 1948 hour..... minute..... M.

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

Bright's Disease  
Chronic myocarditis  
Chronic Bright's disease  
release

Due to.....  
Due to.....

Other conditions (include pregnancy within 3 months of death)

Major findings:  
Of operations..... 1312

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 W. Kinney (M. D. or other)  
Address..... Date signed.....

SUPPLEMENTAL

5-43035