

Registration District No. **209**

Primary Registration District No. **3043**

Registrar's No. **57**

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 **Sewing Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 day** (Specify whether
 In this community **all of life** years, months or days)

3. (a) PRINT FULL NAME **Mary Elizabeth Schmalshof**
 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 **Single**
 6. (b) Name of husband or wife **—** 6. (c) Age of husband or wife if alive **—** years
 7. Birth date of deceased **Oct 28 1943**
 (Month) (Day) (Year)

8. AGE: Years **—** Months **3** Days **8** If less than one day **—** hr. **—** min.

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

10. Usual occupation **—**

11. Industry or business **—**

MOTHER FATHER
 12. Name **James Schmalshof**
 13. Birthplace **Beverly Ill.**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Frances Hays**
 15. Birthplace **Summer Hill Ill.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Margaret E. Schmalshof**
 (b) Address **624 Union St. Hannibal Mo.**

17. (a) **burial** (b) Date thereof **Feb. 8 1944**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Park Lawn Park Ill.**

18. (a) Signature of funeral director **W. M. Smith**
 (b) Address **207 Broadway Hannibal Mo.**

19. (a) **2-8-44** (b) **R. D. 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. **624 Union**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country **—**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **7th**
 year **1944** hour **—** minute **7 P** M.
 21. I hereby certify that I attended the deceased from **Feb 6 - 7 1944**
 to **Feb 6 1944**
 that I last saw her alive on **Feb 6 1944**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary** Duration **—**
 Due to **Heart Failure**
 Due to **—**

Other conditions **—**
 (Include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) **—**
 Date of occurrence **—**
 (c) Where did injury occur? **—** (City or town) (County) (State)
 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. P. Dwyer** (M. D. or other) **MD**
 Address **Hannibal Mo.** Date signed **2-7-44**

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

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

Body Not Embalmed

Registered Apprentice No.

working under my personal supervision.

Signed

Wm M Smith

Licensed Embalmer No.

1204

P. O. Address

Hammil Ave

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 15

State File No. _____
Registrar's No. 57

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

7. Birth date of deceased Oct 2 (Month) (Day) (Year)

8. AGE: Years — Months 2 Days — (Unless 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 _____ (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 _____ (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 7 day _____ year 1944 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. Immediate cause of death Pneumonia

Duration

Due to Heart failure

Due to Branchio Pneuonia

Other conditions (Include conditions within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Major findings: _____
Of operation: _____
Of autopsy: _____
107

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

7751