

U.S. 2  
FORM 3-43  
REV. 5-17-39  
P 1 X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18641

FILED MAY 25 1944

State File No. \_\_\_\_\_

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 128

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

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3  
4

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal

(c) Name of hospital or institution: Levering Hospital  
(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 64

(c) City or town Hannibal 5  
(If outside city or town limits, write "RURAL")

(d) Street No. 810 Center 7  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ 0

3. (a) PRINT FULL NAME Miss Annie Johnson

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7  
year 1944 hour 11 minute A M.

21. I hereby certify that I attended the deceased from Apr 6 - 44  
Apr 6 1944 to Apr 7 1944  
that I last saw her alive on Apr 7 1944  
and that death occurred on the date and hour stated above.

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

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

7. Birth date of deceased October 5 1861  
(Month) (Day) (Year)

Immediate cause of death Pneumonia Duration \_\_\_\_\_

Due to Influenza

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

8. AGE: Years Months Days If less than one day  
82 6 2 hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

Major findings:  
Of operations \_\_\_\_\_

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER

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

12. Name John A. Johnson

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

14. Maiden name Elizabeth DeSpada

15. Birthplace Baltimore Maryland  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. F. Harvey

(b) Address 810 Center

17. (a) Burial (b) Date thereof 4/9/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet

18. (a) Signature of funeral director Wm M. Smith

(b) Address 902 Broadway

19. (a) 4-12-44 (b) R.W. Connor  
(Date received local registrar) (Registrar's signature)

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 A. B. Blue (M. D. or other) \_\_\_\_\_  
Address Hannibal Mo Date signed Apr 8 44

1146

(Licensed Embalmer's Statement on Reverse Side)

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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 George T. Bond

Licensed Embalmer No. 4373

P. O. Address Hannibal, 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.**