

S. No. 2  
M-2-43  
5-17-39  
X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 18648

FILED JUN 23 1944

Primary Registration District No. 3043

Registrar's No. 158

2700  
4  
3  
4

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:  
1215 Lyon 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 \_\_\_\_\_ 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") <sup>4</sup>

(d) Street No. 1215 Lyon st  
(If rural, give location)

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

3. (a) PRINT FULL NAME SAMMUEL W. MCDANIELL

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30 year 1944 hour 4 minute A. M.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased: Dec. (Month) 7 (Day) 1866 (Year)

21. I hereby certify that I attended the deceased from April 1 1944 to April 30 1944 that I last saw him alive on April 30 1944 and that death occurred on the date and hour stated above.

8. AGE: Year 83 Months 4 Days 23 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: Wrennie's Paroxysm <sup>10 day</sup>  
Winney's Stenosis <sup>4 wk</sup>

9. Birthplace New Hartford Mo (City, town, or county) (State or foreign country)

10. Usual occupation Retired farmer

Due to Hypertrophy of Prostate

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

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

12. Name Maybelle McDaniel

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

14. Maiden name Martha Haralson

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

Major findings: 137a

Of operations \_\_\_\_\_

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Ruby Williams (b) Address Hannibal Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-3-44 (Month) (Day) (Year)

(c) Place: burial or cremation Wardonia Mo

18. (a) Signature of funeral director Jas. Donnell (b) Address Hannibal Mo

19. (a) 5/10/44 (Date received local registrar) (b) W. Johnson (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 0

23. Signature J. B. Hester (M. D. or other) <sup>5-3-44</sup>  
Address Hannibal, Mo. Date signed \_\_\_\_\_

1146

**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. Donnell* .....

Licensed Embalmer No. *3246* .....

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.**

*40 110*