

FILED NOV 10 1944

Registration District No.

Primary Registration District No. 3043

Registrar's No. 322

1. PLACE OF DEATH:

(a) County Marion (b) City or town Hannibal (c) Name of hospital or institution St. Elizabeths Hospital (d) Length of stay: In hospital or institution 10 days (e) Citizen of foreign country? No (f) In this community Life time

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Superior 64 (c) City or town County Hospital (d) Street No. (e) Citizen of foreign country? No (f) If yes, name country

3. (a) PRINT FULL NAME EMILY C. MANN

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 9

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

7. Birth date of deceased. About 1862 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day About 82 hr. min.

9. Birthplace. Marion County Mo. (City, town, or county) (State or foreign country)

10. Usual occupation. Housekeeper

11. Industry or business.

12. Name. Given name not known (Dunn)

13. Birthplace. Not known (City, town, or county) (State or foreign country)

14. Maiden name. Given name not known (Brower)

15. Birthplace. Not known (City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records (b) Address at County Infirmary

17. (a) Burial, cremation, or removal. Marion Co. Mo. (b) Date thereof. Oct. 7 - 1944 (c) Place: burial or cremation. Bethany Cemetery

18. (a) Signature of funeral director. R M Sprague (b) Address. Palmyra Mo.

19. (a) 10-14-44 (Date received local registrar) (b) R M Sprague (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 6 year 1944 hour 9 minute 32 A.M.

21. I hereby certify that I attended the deceased from Sept - 26, 1944 to Oct - 6, 1944 that I last saw her alive on Oct - 5, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death. Emphysema of left leg. Due to arterio sclerosis + thrombosis

Other conditions. 99:1 (Include pregnancy within 3 months of death)

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). (b) Date of occurrence. (c) Where did injury occur? (d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature R M Sprague (M. D. or other) Address Homer Mo. Date signed 10-11-44

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

MOTHER FATHER

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 A. M. Sprague

Licensed Embalmer No. 999

P. O. Address Palmyra 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.