

FILED MAR 6 1945

Registration District No. 207

Primary Registration District No. 3043

Registrar's No. 19

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.
In this community Lexington Hospital (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Josephine Hill

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 Married

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

7. Birth date of deceased Jan. 8, 1891
(Month) (Day) (Year)

8. AGE: Years 64 Months 5 Days 8 If less than one day hr. _____ min.

9. Birthplace St Charles Co MO
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name August T. Jaffron

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

14. Maiden name Hickman

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

16. (a) Informant Frank Hill

(b) Address Center MO

17. (a) Removal (b) Date thereof Jan-19-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenview, Ill

18. (a) Signature of funeral director James O'Donnell

(b) Address Hannibal MO

19. (a) Jan 17-45 (b) R. H. Connor
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Marion

(c) City or town Hannibal (Rural)
(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 Jan day 16
year 1945 hour _____ minute 6 A.M.

21. I hereby certify that I attended the deceased from Jan. 9, 1945 to Jan. 16, 1945
that I last saw her alive on Jan. 16, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac embolism

Due to _____

Due to _____

Other conditions Fractured femur
(Include pregnancy within 3 months of death)

Major findings:
Of operations 1750-8

Of autopsy 3

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Fractured femur

(b) Date of occurrence Jan 10 1945

(c) Where did injury occur? Center MO
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
farm - pushed over a car
While at work? yes (Specify type of place) (e) Means of injury _____

23. Signature John P. Reel (M. D. or other)
Address 101 1/2 North Main St Hannibal MO Date signed 1/17/45

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

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

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. O'Connell
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.