

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

No. 2
-2-43
5-17-39
X32997

FILED SEP 20 1945
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:
1010 Collier St
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Marion Co

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

(d) Street No. 1010 Collier
(If rural, give location)

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

3. (a) PRINT FULL NAME Maud Johnson Giller

(b) If veteran, name war _____

(c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 18
year 1945 hour 11 minute 35 PM

21. I hereby certify that I attended the deceased from 5-5
1945 to 8-18-45
that I last saw her alive on Aug-17-45
and that death occurred on the date and hour stated above.

4. Sex Female
5. Color or race Negro
6. (a) Single, widowed, married, divorced, widowed
6. (c) Age of husband or wife if alive, years 15-18-91

7. Birth date of deceased: 7 (Month) 15 (Day) 1891 (Year)

Immediate cause of death
Coronary Thrombosis
Due to: Cardiac Neptretin
Sclerosis

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

8. AGE: Years 54 Months 1 Days 3
If less than one day hr. _____ min. _____

9. Birthplace: MO (City, town, or county) _____ (State or foreign country)

10. Usual occupation: House wife

11. Industry or business _____

12. Name: Henry Johnson

13. Birthplace: Ky (City, town, or county) _____ (State or foreign country)

14. Maiden name: Anna Anderson

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

Major findings:
Of operations _____
Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

16. (a) Informant: Henry Johnson
(b) Address: 1010 Collier St

17. (a) Burial (b) Date thereof: 8-21-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Robinson Cem.

18. (a) Signature of funeral director: Geo E Roberts
(b) Address: Hannibal Mo

19. (a) 9-11-45 (b) Dr. E.M. Lucke
(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? _____
(If Means of injury)

23. Signature: W. A. Fox (M. D. or other)
Address: Hannibal Mo Date signed: Aug 24 1945

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

1398

1945

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 Geo E Roberts

Licensed Embalmer No. 2113

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30964
Registrar's No. 262

Registration District No. 209

Primary Registration District No. 3043

1. PLACE OF DEATH:

(a) County marion
(b) City or town Harrodsburg
(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 Maud J. Allen

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

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased July 15 (Month) (Day) (Year)

8. AGE: Years 54 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 July Day 18
Year 1945 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to Chronic nephritis

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy 1311

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) (a) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

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

