S. No. 2
OM—5-43
v. 5-17-39
o I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 5 1946

State File No. 41851

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 372

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

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Elibabeth Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Oct. 1945 (Specify whether
In this community 2 Months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill. (b) County Pike 9 79

(c) City or town Hull 11
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Bessie Anna Thomas

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 Seth Thomas

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased March (Month) 7 (Day) 1894 (Year)

8. AGE:

Years	Months	Days	If less than one day
51	8	7	hr. min.

9. Birthplace Hull, ILL. (City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name Dr. Calvin Carder
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lydia Griffin
15. Birthplace Plainville Ill. (City, town, or county) (State or foreign country)

16. (a) Informant Mr. Seth Thomas
(b) Address Hull, Ill.

17. (a) ~~Burial &~~ Removal (Burial, cremation, or removal) (b) Date thereof 12-18-45 (Month) (Day) (Year)
(c) Place: burial or cremation Kinderhook Ill

18. (a) Signature of funeral director Crawford Smith
(b) Address 902 Broadway Hannibal, Mo.

19. (a) 12-14-45 (Date received local registrar) (b) Dr. E. M. Lucke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 14
year 1945 hour 6 minute 00 A M.

21. I hereby certify that I attended the deceased from Nov 1, 1945, to Dec 14, 1945
that I last saw her alive on Dec 14, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Ca of ovary c metastases	
Due to	
Due to	
Other conditions: Sepsis (Include pregnancy within 3 months of death)	
Major findings: Of operations 49 W	
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? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

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

1394 (Licensed Embalmer's Statement on Reverse Side)

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 Crawford Smith

Licensed Embalmer No. 3814

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.