

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3302

FILED FEB 20 1946

State File No. \_\_\_\_\_  
Registrar's No. 13

Registration District No. 207 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: 1233 Ledford St  
(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 Mo (b) County Marion

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

(d) Street No. 1233 Ledford St  
(If rural, give location)

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

3. (a) PRINT FULL NAME Anna B. Day

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased 2 20 1886  
(Month) (Day) (Year)

8. AGE: Years 59 Months 10 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House wife

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

MOTHER FATHER

12. Name Mose Arnold

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

14. Maiden name Ellen Brown

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

16. (a) Informant Harvey Day

(b) Address 1233 Ledford St

17. (a) Burial (b) Date thereof 12 23 46  
(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) 1-7-46 (b) Dr. E. M. Lucke  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 21  
year 45 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from 11-8-45 to 12-31-45  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac thrombosis

Due to angina + Myo Carditis

Due to \_\_\_\_\_

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

PHYSICIAN

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy 032

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
(a) Means of injury \_\_\_\_\_

23. Signature Dr. G. W. Fox (M. D. or D.O.) \_\_\_\_\_  
Address Hannibal Mo Date signed 1-2-46

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

100671

**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 \_\_\_\_\_

Licensed Embalmer No. 2113

P. O. Address. Hannibal 770

**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.**