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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
FILED APR 22 1946 STANDARD CERTIFICATE OF DEATH

13876

State File No. _____

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 132

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:
Residence 704 Section, 1
(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)

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion 64

(c) City or town Hannibal 3
(If outside city or town limits, write "RURAL")

(d) Street No. 704 Section 4
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Henry Howard Taliaferro

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Grace ~~Stander~~ Broemmer 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased September 27, 1879
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>66</u>	<u>6</u>	<u>4</u>	hr. _____ min. _____

9. Birthplace Cincinnati Landing Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Lunch Room

11. Industry or business Tally's Lunch Room

12. Name Philip Howard Taliaferro

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

14. Maiden name Elizabeth Guthrie

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

16. (a) Informant Mrs. Henry Taliaferro

(b) Address Hannibal Missouri

17. (a) Burial (b) Date thereof 4/3/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Olivet

18. (a) Signature of funeral director Edward Smith

(b) Address 902 Broadway Hannibal

19. (a) 4-2-46 (b) Dr. E. M. Lucke
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1 year 1946 hour 6 minute 35 A.M.

21. I hereby certify that I attended the deceased from March 31 1946 to March 31 1946:
that I last saw him alive on March 31 1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Bronchial Pneumonia
Pulmonary T.B.s?

Due to _____

Generalized Circumstances
of abdominal cavity

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy not performed

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature B. J. Murray (M. D. or other) _____

Address Hannibal Mo Date signed 4-2-46

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(Licensed Embalmer's Statement on Reverse Side)

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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 Missouri.....

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.

Registration District No. 209

Primary Registration District No. 3043

1. PLACE OF DEATH:

(a) County Maniwa
(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 _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Henry H. Taliferro

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

4. Sex m 5. Color or race w 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 Sept 27 (Month) (Day) (Year)

8. AGE: Years 66 Months 6 Days 20 (Unless than one day) hr. _____ min. _____

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

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) (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 April year 1946 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 _____

Carcinoma small intestine

Due to _____
Due to _____

Other conditions _____ (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? _____ (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) (e) Means of injury _____

23. Signature Bh. Murphy (M. D. or other) M.D.
Address Hannibal - Mo. Date signed 4-26-46

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

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SUPPLEMENTARY

13876