

FILED JUN 12 1946

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 178

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: 511 Ely St. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community at least 5 1/2 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Ralls co 87  
(c) City or town Center (If outside city or town limits, write "RURAL")  
(d) Street No. 0 (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11  
year 1946 hour 3 AM minute 30 M.

21. I hereby certify that I attended the deceased from Jan. 1 to May 11 1946  
that I last saw her alive on May 1 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of breast Duration 1 1/2

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

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

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

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

Of autopsy \_\_\_\_\_

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 H. S. Koster (M. D. or Veter.)  
Address Hannibal mo Date signed 5-21-46

PHYSICIAN

Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Lemuel Freeman Davis

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex male 5. Color or race W 6. (a) Single, widowed, married, divorced widowed

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

7. Birth date of deceased Oct 19 1865  
(Month) (Day) (Year)

8. AGE: Years 80 Months 6 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

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

12. Name Andrew Jackson Davis

13. Birthplace Boyanston Quebec Canada (City, town, or county) (State or foreign country)

14. Maiden name Margh Disker

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

16. (a) Informant Tom Davis son

(b) Address Center mo

17. (a) Burial (b) Date thereof May 13 46 (Burial, cremation, or reinterment) (Month) (Day) (Year)

(c) Place: burial or cremation St. Olivet cemetery

18. (a) Signature of funeral director Couch & Wilkey

(b) Address Couch & Wilkey Center Mo

19. (a) 5-13-46 (b) Dr. E. M. Lucke (Date received local registrar) (Registrar's signature)

MOTHER FATHER

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

**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 A. M. O'Connell

Licensed Embalmer No. 3889

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.**