

No. 2  
M-5-43  
5-17-39  
I X36671

**FILED** JUN 12 1946

Registration District No. 209

Primary Registration District No. 3043

State File No. \_\_\_\_\_

Registrar's No. 151

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:  
# Hogg Rowe  
(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 770 (b) County Marion

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

(d) Street No. a Hogg Rowe  
(If rural, give location)

(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Leonia Marshall

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 11  
year 1946 hour 3 minute 9 M.

21. I hereby certify that I attended the deceased from 4-11-46 to 4-11-46  
that I last saw her alive on 4-4-46  
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. (b) Name of husband or wife Tom Marshall

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

7. Birth date of deceased 3 2 1893  
(Month) (Day) (Year)

Immediate cause of death bronchopneumonia

Due to Myocarditis

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

8. AGE: Years 53 Months 1 Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

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

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

10. Usual occupation domestic

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

12. Name Raymond Smith

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

14. Maiden name Ella Jones

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

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? \_\_\_\_\_

16. (a) Informant Aida Campbell

(b) Address 925 S Arch St

17. (a) Burial (b) Date thereof 4-14-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Captist Cem

23. Signature Dr. A. J. Stoy (M. D. or other) \_\_\_\_\_

Address Hannibal Date signed 4-19-46

18. (a) Signature of funeral director Geo E Roberts

(b) Address Hannibal Mo

19. (a) 4-20-46 (b) W E M Lucke  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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

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1946

**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, on.....

..... Registered Apprentice No. ....  
working under my personal supervision.

Signed Joe 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.**