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M-5-43  
7. 5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **17379**  
Registrar's No. **149**

Registration District No. **209** 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:  
Levering Hospital  
(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 Missouri (b) County Marion  
(c) City or town Hannibal  
(If outside city or town limits, write "RURAL")  
(d) Street No. 708 North Hawkins  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charles Percy  
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 Married  
6. (b) Name of husband or wife Dollie Smoot Percy 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 27, 1871  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 12 year 1946 hour 2 minute 55 A. M.  
21. I hereby certify that I attended the deceased from April 5th to April 11, 1946  
that I last saw him alive on April 11, 1946 and that death occurred on the date and hour stated above.  
Immediate cause of death Carcinoma of prostatic gland  
Duration 1 yr

8. AGE: Years Months Days If less than one day  
74 11 19 hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace York Ontario Canada 2  
(City, town, or county) (State or foreign country)  
10. Usual occupation Retired  
11. Industry or business Railroad  
12. Name Robert Percy  
13. Birthplace New Castle England 4  
(City, town, or county) (State or foreign country)  
14. Maiden name Jane C. Straton  
15. Birthplace Hamilton Ontario 2  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Dollie Smoot Percy  
(b) Address 708 North Hawkins, Hannibal  
17. (a) Burial (b) Date thereof 4/13/46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mount Olivet  
18. (a) Signature of funeral director Crawford Smith  
(b) Address 902 Broadway Hannibal Missouri  
19. (a) 4-17-46 (b) Dr. E. M. Lucke  
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury \_\_\_\_\_  
23. Signature J. B. Shiltan M.D. Date signed 4-15-46  
Address 500 Broadway

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

200

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(Licensed Embalmer's Statement on Reverse Side) Hannibal, Mo.

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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. 2814  
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.**