

**FILED** SEP 27 1946

STANDARD CERTIFICATE OF DEATH

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

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 303

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 St Elizabeth 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

3. (a) PRINT FULL NAME Plyde Franklin Fatcher

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

4. Sex Male 5. Color negro 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Ester Mae 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased 2 23 1918  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>28</u>	<u>6</u>	<u>15</u>	hr. _____ min. _____

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

10. Usual occupation Laborer

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

12. Name John Fatcher

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

14. Maiden name Mildred Foster

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

16. (a) Informant Mrs John Fatcher

(b) Address Hannibal, Mo.

17. (a) Burial (b) Date thereof 9-13-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Robinson Glen

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

(b) Address Hannibal Mo

19. (a) 9-19-46 (b) Dr. E. M. Lucke  
(Date received local registrar) (Registrar's signature)

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. 5 Myers Row  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 8 year 46 hour 2 minute 45 pm

21. I hereby certify that I attended the deceased from Aug 14 to 46 Sept 8 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Lymphatic Leucemia

Due to Lymphatic Leucemia

Due to Lymphatic Leucemia

Other conditions Lymphatic Leucemia  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy 74A

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 W. H. Meeker (M. D. or other) \_\_\_\_\_  
Address Hannibal Mo Date signed 9/19/46

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

20700

**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 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.**