S. No. 2
M—5-43
5-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 5 1947

Registration District No. 289

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 30435766

State File No. 1784

Registrar's No. 32

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 0
(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 64

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

(d) Street No. 913 Center 4
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No) 0

If yes, name country .....

3. (a) PRINT FULL NAME Della Fowkes

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

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

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Ernest Fowkes

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

7. Birth date of deceased October 8, 1867 (Month) (Day) (Year)

8. AGE: Years 79 | Months 3 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace Higbee Missouri (City, town, or county) 0 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business XX

FATHER
12. Name John Henry Carroll 9
13. Birthplace No record (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Cordelia Pitney
15. Birthplace No record (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs. Frances Britt 1

(b) Address Kansas City Kansas

17. (a) Burila (Burial, cremation, or removal) (b) Date thereof 1/14/47 (Month) (Day) (Year)

(c) Place: burial or cremation Mount Olivet

18. (a) Signature of funeral director W. Crawford Smith

(b) Address Hannibal Mo

19. (a) 1-15-47 (Date received local registrar) (b) Dr E. M. Lucke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 13 year 1947 hour 10 minute 40 A. M.

21. I hereby certify that I attended the deceased from Dec. 26, 1946, to Jan. 13, 1947 that I last saw her alive on Jan. 13, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of left Hip.

Due to a fall

Due to .....

Other conditions Same mental condition
(Include pregnancy within 3 months of death)

Major findings:
Of operations —

Of autopsy —

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

186 18

SEDITIONED UNLESS OTHERWISE REQUESTED

22. If death was due to external causes, fill in the following: 119

(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? ..... (Specify type of place)

While at work? ..... (e) Means of injury 0

23. Signature J. C. Chilton (M. D. or other)

Address 5 Broadway Date signed Jan 13 47

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(Licensed Embalmer's Statement on Reverse Side)

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 W. 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.

No. 2B
-3-45
X43880

WRITE PLAINLY—USE UNFADING BLACK I... MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 32

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:
(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 (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

3. (a) PRINT FULL NAME Della Fourher

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

4. Sex F
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 years
7. Birth date of deceased Oct (Month) 8 (Day) 1867 (Year)

8. AGE: Years 79 Months 3 Days If less than one day hr. min.

9. Birthplace (City, town, or county) MO (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jan day 13
year 1947 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death Fell and fractured Hip. R side Dec 29-46 at Home fell On Stairway
Due to
Due to 3 steps
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

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) Accident
(b) Date of occurrence 12-29-47
(c) Where did injury occur? Hannibal (City or town) Marion (County) Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury
23. Signature J. A. Schiltner (M. D. or other) M.D.
Address 506 Broadway, Hannibal Mo. Date signed 2-11-47

SUPPLEMENTARY

5-1784