

S. No. 2
OM-5-43
v. 5-17-39
I X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 5 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1785

State File No. _____

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 21

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: Leveering 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 _____ (Specify whether)
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. 808 Bridge St 4
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Gimble
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

20. DATE OF DEATH: Month Jan day 3rd
year 1947 hour _____ minute 9:50 P.M.
21. I hereby certify that I attended the deceased from Dec 21st
1946 to Jan 3 19 1947

that I last saw him alive on Jan 3 19 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer
Due to _____
Due to _____

Other conditions Stenocardia
(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 John P. Lucke (M. D. or other) _____
Address 104 1/2 Poling Street Date signed 1947

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Elizabeth 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased December 15 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 - 19 hr. min. 0

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

10. Usual occupation Retired

11. Industry or business _____

12. Name UNKNOWN 9

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

14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Walter Willingham
(b) Address 801 Bridge St Hannibal Mo

17. (a) Burial (b) Date thereof Jan 7 1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Crematorium Burial Park

18. (a) Signature of funeral director James O'Connell
(b) Address Hannibal Mo

19. (a) Jan 13 47 (b) Dr E M Lucke
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *H. 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.