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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED FEB 6 1947**  
Registration District No. 209

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1794  
Registrar's No. 51

Primary Registration District No. 3043

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

1. PLACE OF DEATH:  
(a) County Marion  
(b) City or town Hannibal  
(c) Name of hospital or institution: 4024 North Main St.  
(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 Shelby 102  
(c) City or town Clarence 1  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 1  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Herbert McSorley  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 16  
year 1947 hour \_\_\_\_\_ minute 5.30PM

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Ina Bell (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Jan 14 1888  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1-3 1947 to 1-16 1947  
that I last saw him alive on 1-16 1947  
and that death occurred on the date and hour stated above.

8. AGE: Years 59 Months - Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Congestive Heart Failure Duration 2 yr

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

Due to valvular Disease of Heart  
Due to \_\_\_\_\_

10. Usual occupation Farmer

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

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

Major findings: Of operations 93D  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
-Underline the cause to which death should be charged statistically.

12. Name Hance McSorley

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 Ina Bell Mc Sorley

(b) Address Hannibal, Missouri

17. (a) Burial (b) Date thereof 1-20-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clarence, Mo.

18. (a) Signature of funeral director C. C. Hopper

(b) Address Clarence, Mo.

19. (a) 1-27-47 (b) Dr. C. M. Luke  
(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 and  
(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 0  
23. Signature Handley M P (M. D. or other) 0  
Address Hannibal, Mo. Date signed 1-24-47

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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..... *L. M. O'Donnell*  
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.**