

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

FILED FEB 5 1947  
Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 14

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

4  
3  
4

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion

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

(d) Street No. 1506 E Gordon 4  
(If rural, give location) 0

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Genevra Postor

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

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

4. Sex Female 5. Color or race Negro

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

6. (b) Name of husband or wife David Postor

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

7. Birth date of deceased 12 20 1904  
(Month) (Day) (Year)

8. AGE: Years 42 Months 0 Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

12. Name Wm Seals

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

14. Maiden name No record

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant David Postor

(b) Address 1506 E Gordon

17. (a) Burial (b) Date thereof 1-8-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Robinson

18. (a) Signature of funeral director GEO E ROBERTS

(b) Address Hannibal Mo

19. (a) 1-9-47 (b) Dr E M Lucke  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 5  
year 1947 hour 3 minute AM

21. I hereby certify that I attended the deceased from Dec 20 1946 to Jan 5/47 1947  
that I last saw him alive on Jan 5/47 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to Cancer of Uterus

Due to \_\_\_\_\_

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy 48B

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) \_\_\_\_\_

(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) \_\_\_\_\_

Means of injury \_\_\_\_\_

23. Signature J. M. Tucker (M. D. or other) \_\_\_\_\_

Address Hannibal Mo Date signed 1/9/47

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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.....

*Gas E Roberts*

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.**