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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 9 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9991**
Registrar's No. **127**

Registration District No. **209** 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**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **616 Center 1**
(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 **Lina Wayne**
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** **Married**
6. (b) Name of husband or wife **Benjamin T. Wayne** **(c) Age of husband or wife if alive** _____ years
7. Birth date of deceased **December 20, 1868**
(Month) (Day) (Year)

8. AGE: Years **78** Months **78** Days **3** **4** If less than one day _____ hr. _____ min.

9. Birthplace _____ **New Orleans**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business
12. Name **Peter Hicker maid** **9**
13. Birthplace **unknown** **9**
(City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace _____ **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **B.T. Wayne Jr**

(b) Address **323 Broadway Hannibal MO**

17. (a) Burial **(b) Date thereof** **March 25 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Grainview Burial Park**

18. (a) Signature of funeral director **James O'Connell**

(b) Address **Hannibal MO**
19. (a) 3-28-47 **(b) Dr E M Lucke**
(Date received local registrar) (Registrar's signature)

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. **616 Center** **4**
(If rural, give location) **0**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **24**
year **1947** hour _____ minute **40** **40** A.M.
21. I hereby certify that I attended the deceased from **Jan 1 47**
19 to **March 24 47**
19 that I last saw her alive on **Mar 27 47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Premia's lob** **Duration** **6 hrs**
Due to **Perforation Artery** **57**

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____ **108**
Of autopsy _____
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.B. [Signature]** (M. D. or _____)
Address **[Address]** **Date signed** **3/28/47**

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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. 497
working under my personal supervision.

Signed H. M. O'Connell
Licensed Embalmer No. 3889
P. O. Address Hannibal

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.