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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JUL 3 1947**  
Registration District No. 209

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**  
Primary Registration District No. 3043

State File No. 21609  
Registrar's No. 245

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: 1020 Vine 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 Lifetime (Specify whether  
in years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Marion  
(c) City or town Hannibal  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1020 Vine  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country -----

3. (a) PRINT FULL NAME LAURA RUBY DOWDS  
3. (b) If veteran, name war -----  
3. (c) Social Security No. -----

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June day 19  
year 1947 hour 6 minute 40 p.m.

4. Sex female 5. Color or race white  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Charles Dowds  
6. (c) Age of husband or wife if alive --- years  
7. Birth date of deceased October 5 1874  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb 15 1947, to 19 June 1947  
that I last saw her alive on 18 June, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage  
Duration -----

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>8</u>	<u>14</u>	hr. <u>-----</u> min. <u>-----</u>

Due to cerebral arteriosclerosis

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

Due to -----

10. Usual occupation housewife

Other conditions (Include pregnancy within 3 months of death) 83A

11. Industry or business -----

Major findings: Of operations -----

MOTHER FATHER { 12. Name Joseph Rubison

Of autopsy -----  
Underline the cause to which death should be charged statistically.

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

14. Maiden name Eliza Longeell

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

16. (a) Informant Mrs. Louella McCormack

(b) Address R. # 3, Lee's Summit, Mo.

17. (a) burial (b) Date thereof 6/21/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Ray P. Schmitt

(b) Address 1000 Broadway, Hannibal, Mo.

19. (a) 6-26-47 (b) W. E. M. Lucke  
(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 -----

(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? 0

While at work? (Specify type of place) (e) Means of injury -----

23. Signature W. J. Green (M. D. or other) M.D.

Address 1132 1/2 Main Date signed 23 June 1947  
Hannibal Mo

**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

*Paul Richard [Signature]*

Licensed Embalmer No.

*4326*

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.**