

FILED JUL 14 1947

Registration District No. 209

Primary Registration District No. 4320

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Palmyra  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
County Infirmary 5  
(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 Nancy Alcorn  
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, Widowed  
6. (b) Name of husband or wife James Alcorn  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased October 14, 1981  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
65 10 3 hr. min.

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

10. Usual occupation Housework

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

12. Name Thomas Fields  
13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Gladys Alcorn Parker  
(b) Address St. Louis Missouri

17. (a) Burial (b) Date thereof 6/19/47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mount Olivet

18. (a) Signature of funeral director Manufacturers  
(b) Address 902 Broadway Hannibal Missouri

19. (a) 6-20-1947 (b) Viola Lee Deputy  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion  
(c) City or town Palmyra  
(If outside city or town limits, write "RURAL")  
(d) Street No. County Infirmary  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17  
year 1947 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from May 1  
to June 17, 1947  
that I last saw him alive on July 9, 1947  
and that death occurred on the date and hour stated above.  
Duration 1

Immediate cause of death  
Paramecia of sigmoid & colon

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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) (e) Means of injury \_\_\_\_\_  
23. Signature E. M. Jucke (M. D. or other) \_\_\_\_\_  
Address Hannibal Date signed 6-18-47

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

MOTHER FATHER

**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. Crawford Smith*

Licensed Embalmer No. 3814

P. O. Address Hannibal Missouri

**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.**

2B  
15  
3880

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

State File No. July  
Registrar's No. 40

Registration District No. 209

Primary Registration District No. 4320

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Palmyra  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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 Nancy Alcorn  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct 14 (Month) 14 (Day) 1900 (Year)

8. AGE: Years 65 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housework

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

MOTHER FATHER

12. Name \_\_\_\_\_  
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 \_\_\_\_\_  
(b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) \_\_\_\_\_  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH Month July Day 19 Year 1900 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

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

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

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

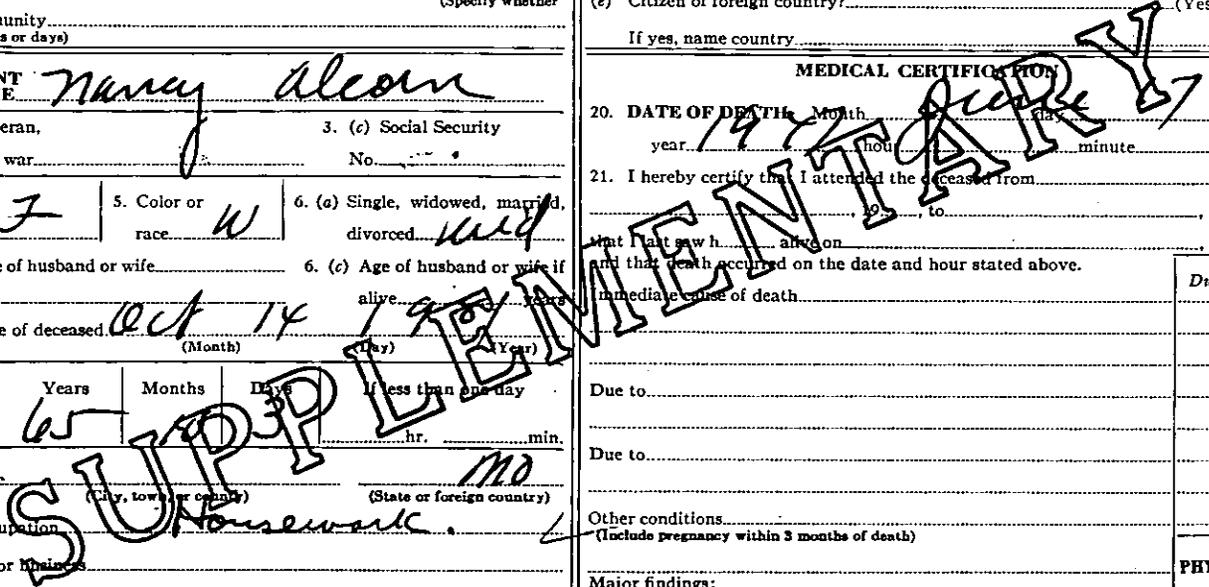
PHYSICIAN

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) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_



S-21635