

FILED AUG 13 1947

Registration District No.

Primary Registration District No. 3043

Registrar's No. 288

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

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Elizabeth Hospital Hannibal Mo
(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 ETTAMAR GLAHN

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 Arthur Glahn

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased: 7 (Month) 30 (Day) 1880 (Year)

8. AGE: Years 67 Months 0 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Porter

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

14. Maiden name unknown

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

16. (a) Informant Ellis Glahn

(b) Address Phila Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-3-1947
(Month) (Day) (Year)

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

18. (a) Signature of funeral director B. M. Allen

(b) Address Philadelphia Missouri

19. (a) 8-6-47 (Date received local registrar) (b) W. R. M. Fuchs (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion

(c) City or town Rural Philadelphia
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 31 day July
year 1947 hour 11 minute 40 P.M.

21. I hereby certify that I attended the deceased from _____
19 47 to _____
19 47 and that death occurred on the date and hour stated above.

Immediate cause of death: Hemorrhage from Colon into R.A.

Due to _____

Due to _____

Other conditions: slightly ek myocardia
(Include pregnancy within 3 months of death)

Major findings: none

Of operations none

Of autopsy H&E

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence: 8-3-47

(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? _____

(Specify type of place)

(c) Means of injury _____

23. Signature: W. R. M. Fuchs (M. D. or other) _____

Address: 121 N. 1st Hannibal Mo Date signed: 8/2/47

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

AUG 22 1947

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..... *B M Allen*

Licensed Embalmer No. *2437*

P. O. Address *Philadelphia Miss*

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.