

No. 2
M-5-43
5-17-39
I 38621

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24827
Registrar's No. 267

Registration District No. 209 Primary Registration District No. 3043

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:
2920 Market 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 Samuel A. Magee
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife Clara Bell Age of husband or wife if alive _____ years
 7. Birth date of deceased Nov 9 1865
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 7 23 hr. min.

9. Birthplace Spaulding MO
 (City, town, or county) (State or foreign country)
 10. Usual occupation Retired Merchant
 11. Industry or business Grocer

MOTHER FATHER

12. Name Samuel B. Magee
 13. Birthplace MO
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Elizabeth Robinson
 15. Birthplace KY
 (City, town, or county) (State or foreign country)

16. (a) Informant Geo. R. Magee Sr.
 (b) Address 2920 Market Hannibal MO
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 4 1947
 (Month) (Day) (Year)
 (c) Place: burial or cremation Olivet Cem. Hannibal MO

18. (a) Signature of funeral director James O. Dinnel
 (b) Address Hannibal MO
 19. (a) 7-17-47 (Date received local registrar) (b) Dr. E. M. Lucere (Registrar's signature) 1947

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. 2920 Market
 (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 2nd
 year 1947 hour _____ minute 4:25 M.
 21. I hereby certify that I attended the deceased from 1940
 _____ 19 _____ to July 2 19 47
 that I last saw him alive on July 2 19 47
 and that death occurred on the date and hour stated above.

Immediate cause of death Ch. myocarditis
 Due to _____
 Due to _____
 Other conditions Ch. nephritis
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

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 [Signature] (M. D. or other) _____
 Address 100 Bldg. Hannibal MO Date signed 7/15/47

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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

4
3
4

67
5
4
0

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 Hannock Md

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.