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M-5-43  
5-17-39  
X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28344

State File No. \_\_\_\_\_

FILED SEP 5 1947  
Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 305

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: Levering Hospital  
(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)

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. 2709 Hope St 4  
(If rural, give location) 0

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Johnie Minnie L. Hegintott

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 Herman 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased October 18, 1888  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

58 10 7 hr. min.

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

10. Usual occupation Housewife

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

MOTHER FATHER

12. Name Isaac Smith

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

14. Maiden name Sarah Wilson

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

16. (a) Informant Herman Hegintott

(b) Address 2709 Hope Hannibal Mo

17. (a) Burial (b) Date thereof Aug 27, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grandview Burial Park

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

(b) Address Hannibal Mo

19. (a) 8-30-47 (b) W. S. M. Lucke  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 25 year 1947 hour \_\_\_\_\_ minute 1:25 A.M.

21. I hereby certify that I attended the deceased from 8:23 1947 to 8:25 1947.  
that I last saw her alive on 8:25 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Disease Myocardial Damage 3 Days

Due to My Profuse Cardiovascular Disease a Central Hemorrhage 7 days

Due to Ch. Cholelithiasis 0

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

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

Of autopsy 939

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 W. S. M. Lucke Date signed 8/28/47

Address Hannibal Mo

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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.....

*George A. Magee Jr.*....., Registered Apprentice No. *497*,  
working under my personal supervision.

Signed..... *H. M. O'Connell*.....

Licensed Embalmer No. *3889*.....

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.**