

No. 2
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-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35043**

FILED NOV 4 1947

Registration District No. **209**

Primary Registration District No. **3043**

Registrar's No. **363**

1. PLACE OF DEATH:

(a) County **Marion**
(b) City or town **Hannibal**
(c) Name of hospital or institution: **708 Church St.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **47 years** (Specify whether in this community 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. **708 Church St.**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **---**

3. (a) PRINT FULL NAME **AASA CHRISTINE ERICKSON**

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 **Albert Erickson** 6. (c) Age of husband or wife if alive **---** years

7. Birth date of deceased **December 25 1870**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	76	9	24	- hr. - min.

9. Birthplace **Nordre Vikse, Haugesund, Norway**
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business **----**

12. Name **Bendik Johnsen**

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

14. Maiden name **Berline**

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

16. (a) Informant **Albert Erickson**

(b) Address **708 Church, Hannibal, Mo.**

17. (a) **burial** (b) Date thereof **Oct. 22, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Ray O. Schwartz**

(b) Address **1000 Broadway, Hannibal, Mo.**

19. (a) **10-23-47** (b) **W. E. M. Lucke**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **19** year **1947** hour **1** minute **---** P. M.

21. I hereby certify that I attended the deceased from **Sept 29** 19 **47** to **Oct 19** 19 **47** that I last saw her alive on **Oct 19** 19 **47** and that death occurred on the date and hour stated above.

Immediate cause of death **Angina pectoris**
Ch. myocardiitis
Due to **---**

Due to **---**
Other conditions **Ch. myocardiitis**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **none**
Of autopsy **myocarditis**

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. E. M. Lucke** (M. D. or other)
Address **106 1/2 B. Harrison St.** Date signed **10/22/47**

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

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

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 Brown

Licensed Embalmer No.....

4324

P. O. Address.....

Harrisburg

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.