

S. No. 2
M-1/47
7. 5-17-39

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

FILED NOV 29 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39754
10238
Registrar's No.

Registration District No. 318 Primary Registration District No. 1000 Registrar's No.

1. PLACE OF DEATH:
(a) County Lewis, Mo.
(b) City or town Hannibal
(c) Name of hospital or institution Hannibal Hospo
(d) Length of stay: In hospital or institution. (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County 999
(c) City or town Hannibal, Mo. 06
(d) Street No. 615 WILSON ST. SHREVEPORT La 0
(e) Citizen of foreign country? (Yes or No) 2
If yes, name country.

3. (a) PRINT FULL NAME William Martin HERRIN
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color White
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive - 1888 years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 14
year 1947 hour 10 minute 10 M.
21. I hereby certify that I attended the deceased from
that I last saw him alive on
and that death occurred on the date and hour stated above.

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

Duration
Immediate cause of death
Due to Hemorrhage and shock
of aortic aneurysm
Due to
Other conditions: Cause and manner of death could not be determined
(Include pregnancy within 3 months of death)

8. AGE: Year 39, Months, Days
9. Birthplace: (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
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: Thos F. Callahan
(b) Address: 1300 Clark St
17. (a) Removal (b) Date thereof: 11-5-47
(c) Place: burial or cremation: ceteron - del
18. (a) Signature of funeral director: Ralph A. Bent
(b) Address: 1024 1/2 State St, Ceteron, Del.
19. (a) Date received local registrar: NOV 5 1947 (b) Registrar's signature: J. E. Breneck

PHYSICIAN
Major findings: Of operations: Of autopsy: DETERMINED
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Open Wounded
(b) Date of occurrence: 10/14/47
(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? Public place
While at work? (Specify type of place) decorative
(e) Means of injury:
23. Signature: J. E. Breneck (M. D. or other) 3
Address: Ceteron Date signed: 10/31/47

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

19
17
9

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.