No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JAN 21 1948

MISSOURI DIVISION OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 1762

Registration District No. 209 — Primary Registration District No. 3043 — Registrar's No. 17

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 Foley (If outside city or town limits, write "RURAL")
(d) Street No. ..... (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Lena Belle Fiske
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~~ Single
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years 60 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Ray Co (City, town, or county) Missouri (State or foreign country)
10. Usual occupation School Teacher
11. Industry or business .....
FATHER
12. Name Chas. Fiske
13. Birthplace New York (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Nettie C Bryan
15. Birthplace Missouri (City, town, or county) (State or foreign country)
16. (a) Informant D. W. McCoy
(b) Address Troy Mo
17. (a) Removal (~~Burial, cremation~~, or removal) (b) Date thereof 1-11-48 (Month) (Day) (Year)
(c) Place: burial or cremation Foley Mo
18. (a) Signature of funeral director James Donnell
(b) Address Hannibal Mo
19. (a) 1-12-48 (Date received local registrar) (b) Dr E M Lucke (Registrar's signature) 149

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 9 year 1948 hour 8 minute 50 P. M.
21. I hereby certify that I attended the deceased from Dec. 28, 1947, to Jan. 8, 1948; that I last saw her alive on Jan. 8, 1948; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Cerebral Hemorrhage | 10 days |
| Due to: Cerebral Arteriosclerosis | Yrs. |
| Due to: | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause of 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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature H B Norton (M. D. or other)
Address Hannibal Mo Date signed 1-12-48

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

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

MAR 24 1948

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.....Michael J. O'Donnell

Licensed Embalmer No.....3246

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.