

MISSOURI DIVISION OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No. 4No. 2
1/47
17-39

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED JAN 12 1948

Registration District No. 209Primary 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:
601 COLLIER ST
 (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. 601 COLLIER ST 4
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No) 0
 If yes, name country.....

3. (a) PRINT FULL NAME

Addie Neas
 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 Widow
 6. (b) Name of husband or wife Lee 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased May 28 1873
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>7</u>	<u>8</u> hr. min.

9. Birthplace Pike Co. Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business

12. Name Robert E. Wiggs

13. Birthplace Pike Co. Mo.
 (City, town, or county) (State or foreign country)

14. Maiden name Mary Branches

15. Birthplace Pike Co. Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant Thos. R. H. Haysden

(b) Address 601 Collier St. Hannibal MO

17. (a) Burial (b) Date thereof Jan 8 - 48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wellsville MO

18. (a) Signature of funeral director James O. Daniels

(b) Address Hannibal MO

19. (a) 1-6-48 (b) Dr. E. M. Lude
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 5th year 1948 hour..... minute 4:30 PM

21. I hereby certify that I attended the deceased from February 4, 1947, to Jan 5, 1948; that I last saw her alive on 12-6-, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Sclerosis

Due to Chronic myocarditis with arteriosclerosis

Due to.....

Other conditions.....
 (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?..... (Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature B. D. Wynn (M. D. or other) MD

Address Hannibal MO Date signed 1-6-48

PHYSICIAN

Underline the cause of which death should be charged statistically.

WRITE PLAINLY—USING 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..... *H.M. O'Donnell*

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.