No. 2
1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

5462

State File No.

FILED FEB 19 1948

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 46

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 years, months or days)

In this community .....

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.: 2711 Market St 4
(If rural, give location) 0

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME: Ruby Mae Quinn

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: B. G.

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

7. Birth date of deceased: July (Month) 5 (Day) 1902 (Year)

8. AGE: Years 45 | Months 7 | Days 4 | If less than one day ..... hr. ..... min.

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

10. Usual occupation: House wife

11. Industry or business .....

FATHER
12. Name: Chas. Wiggins
13. Birthplace: — (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: — (City, town, or county) — (State or foreign country)

16. (a) Informant: B. A. Quinn
(b) Address: 27 N Market Hannibal Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 11. 1948 (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) 2-10-48 (Date received local registrar) (b) Dr. E. M. Locke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 9th year 1948 hour ..... minute 3 a M.

21. I hereby certify that I attended the deceased from ....., 19....., to ....., 19.....; that I last saw h..... alive on ....., 19.....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary thrombosis	4 days
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations: Acute cholecystitis
Of autopsy: yes

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) 0

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

23. Signature: B. L. Murphy (M. D. or other) MD

Address: Hannibal Mo Date signed 2-10-48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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. 797, 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.