

FEDERAL SECURITY AGENCY

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

National Office of Vital Statistics
FILED FEB 19 1949

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 47

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: St. Elizabeth's 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: Hannibal 3
(If outside city or town limits, write "RURAL")
(d) Street No.: 212 E 7th St 4
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

CARRIE Elizabeth WACHENDORFER

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21
year 1948 hour 6 minute A M.

21. I hereby certify that I attended the deceased from Jan 19
_____, 1948 to Jan 21, 1948
that I last saw her alive on Jan 21, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis
arterio sclerosis

Due to: Thrombosis of femoral
artery (left)

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. J. Murphy (M. D. or other) MD
Address: Hannibal Mo Date signed: 1-22-48

Duration

?

5 days

PHYSICIAN

Underline the cause of which death should be charged statistically.

4. Sex: Female 5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Charles 6. (c) Age of husband or wife if alive: _____ years
7. Birth date of deceased: Feb 18 1875
(Month) (Day) (Year)

8. AGE: Years 72 Months 11 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace: Hannibal Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business

12. Name: Fred B. Meyer 4

13. Birthplace: Germany
(City, town, or county) (State or foreign country)

14. Maiden name: Louise Steibler

15. Birthplace: Cincinnati Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant: My Sister W. W. Wadendorfer

(b) Address: East Clair Ave

17. (a) Burial (b) Date thereof: 1-21-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: St. Mary's Cemetery

18. (a) Signature of funeral director: James O'Donnell

(b) Address: Hannibal Mo

19. (a) 2-10-48 (b) W. E. Wadendorfer
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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. Daniel

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.