

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

27052
40

State File No.

FILED SEPT 14 1948
209

Registration District No.

Primary Registration District No. ~~3043~~ 5761

Registrar's No.

1. PLACE OF DEATH:

(a) County..... Marion

(b) City or town..... Palmyra
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Infirmary 0
(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..... Palmyra 9
(If outside city or town limits, write "RURAL") 0

(d) Street No..... Infirmary 0
(If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME..... Minnie Jane Hurd

3. (b) If veteran, name war.....

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 24
year 1948 hour 6 minute 30 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.

4. Sex..... Female 5. Color or race..... White

6. (a) Single, widowed, married, divorced..... Widowed

6. (b) Name of husband or wife..... G. W. Hurd 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased..... September 29, 1861
(Month) (Day) (Year)

Immediate cause of death.....
Cerebral Hemorrhage

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>10</u>	<u>25</u>hr.min.

Due to.....

Due to..... 37mo

Other conditions.....
(Include pregnancy within 3 months of death)

9. Birthplace..... New York State
(City, town, or county) (State or foreign country)

10. Usual occupation..... XX

11. Industry or business..... XX

12. Name..... Liba Granger Spring

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

14. Maiden name..... Elizabeth Irene Wade

15. Birthplace..... Pennsylvania
(City, town, or county) (State or foreign country)

16. (a) Informant..... Mrs. Carrie Gleason

(b) Address..... 1215 Lyon, Hannibal Mo.

17. (a) Burial (b) Date thereof..... 8/25/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Mount Olivet

18. (a) Signature of funeral director..... H. Crawford Smith

(b) Address..... 902 Broadway Hannibal Mo.

19. (a) 8-26-48 (b) N. E. M. Lucke
(Date received local registrar) (Registrar's signature)

Major findings:
Of operations..... g36

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..... N. E. M. Lucke (M. D. or other)
Address..... Hannibal Date signed..... 8-25-48

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 _____

J. M. Steele

Licensed Embalmer No. 4541

P. O. Address Hannibal Missouri

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.