

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

FILED APR 11 1949

State File No.

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 115

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 Levee Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 Hours  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ILLINOIS (b) County SANGAMON  
(c) City or town SPRINGFIELD  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3217 1/2 So 6th ST. ROAD.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 2 years.

3. (a) PRINT FULL NAME JUVIAN OLETA HAMRICK

3. (b) If veteran, name war No 3. (c) Social Security No. 348-07-6310

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife FRED HAMRICK 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased FEB. 3-1903  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>46</u>	<u>2</u>	<u>1</u>	hr. min.

9. Birthplace MONROE Co. MO.  
(City, town, or county) (State or foreign country)

10. Usual occupation SALES CLERK

11. Industry or business DRY GOODS STORE

12. Name WILL COLLIFER

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

14. Maiden name MAMIE VEAL

15. Birthplace MONROE Co. MO.  
(City, town, or county) (State or foreign country)

16. (a) Informant Fred W Hamrick

(b) Address 3217 1/2 So 6th St. Springfield, Ill.

17. (a) Funeral removal (b) Date thereof 4-4-49  
(Funeral, cremation, or other) (Month) (Day) (Year)

(c) Place of burial or cremation Sangamon County, Ill.

18. (a) Signature of funeral director Charles Taylor

(b) Address 1109 So 5th St. Hannibal, Mo.

19. (a) 4-4-49 (b) P. E. M. Slucke (c) By W. C. Taylor  
(Date received local registrar) (Registrar's signature) (Deputy)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4th  
year 1949 hour 9 minute 10 A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw her alive on April 4, 1949, and that death occurred on the date and hour stated above.

Immediate cause of death Valvular Embolism Duration 2 days

Due to Valvular Heart disease ?

Due to \_\_\_\_\_

Other conditions 1/2 14  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN  
Underline the cause to 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) (e) Means of injury 0

Signature W. C. Taylor (M. D. or other) \_\_\_\_\_

Address 100 N 6th Hannibal Mo Date signed 4/4/49

JAN 17 1950

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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.