

FILED MAY 16 1949

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 171

1. PLACE OF DEATH:

(a) County Marión
(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 Hosp.
(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) Defunct

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Audrain
(c) City or town Mexico
(If outside city or town limits, write "RURAL.")
(d) Street No. 1020 Jefferson
(If rural, give location)
(f) Citizen of foreign country? _____ (Yes/No)
If yes, name country _____

3. (a) PRINT FULL NAME JOHN P. HARRINGTON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 1

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

7. Birth date of deceased May 4 49
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
5 hr. 15 min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name T. B. Harrington

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

14. Maiden name Alvirna Mae Mayes

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

16. (a) Informant Mrs. Forrest Mayes

(b) Address 1020 N. Jefferson Mexico

17. (a) Buried (b) Date there May 5 1949
(Burial, cremation, etc.) (Month) (Day) (Year)

(c) Place: burial or cremation Almwood Incinerator

18. (a) Signature of funeral director Alvin J. Jones

(b) Address Central Ave

19. (a) 5-9-49 (b) Dr. E. M. Linder
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4th
year 1949 hour 1 pm minute 10 min.

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

Immediate cause of death Trematodynia
stataleis - 1 day
Due to _____
Due to _____

Duration
16 mos & 3 mos.

Other conditions _____
(Include pregnancy within 3 months of death) 7/25

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? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature J. L. Lamborn (M. D. or other)
Address Jans Broadway Date signed _____

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 *Gene Jensen*
Licensed Embalmer No. 4270
P. O. Address Clinton, Mo.

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

If this body is not embalmed, fact should be so stated above.