

FILED JUL 11 1944

State File No. _____

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 187

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: 1220 Girard St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT
FULL NAME

Melinda Settles

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Chas Settles 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: (Month) 1 (Day) 1 (Year) 54

8. AGE: Years 89 Months 5 Days 10 If less than one day
hr. _____ min. _____

9. Birthplace Florida (City, town, or county) mo b (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

12. Name Phill Lawson

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

14. Maiden name _____

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

16. (a) Informant Mrs Buelah Gross

(b) Address 1220 Girard St

17. (a) Burial (b) Date thereof 5-30-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Robinson bfm

18. (a) Signature of funeral director Geo E Roberts

(b) Address Hannibal mo

19. (a) 6-6-44 (b) R M Connor
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State 7770 (b) County Marion
(c) City or town Hannibal
(If outside city or town limits, write "RURAL")
(d) Street No. 1220 Girard St
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 28
year 44 hour 11 minute 15

21. I hereby certify that I attended the deceased from May 26-44 to May 28/44
that I last saw her alive on May 28/44
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Wrenca
Due to _____
Due to Chronic Nephritis
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: 131h
Of operations _____
Of autopsy _____

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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 H B M Meekins (M. D. or other) MD
Address Hannibal Mo Date signed 6/5/44

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.....

Geo E Roberts

Licensed Embalmer No. *2113*

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.