

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

Rev. 5-17-39

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7383

Registration District No. 547

Primary Registration District No. 3079

Registrar's No. 76

1. PLACE OF DEATH:

(a) County Marion
 (b) City or town Hannibal mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution 208 N 8th St
 (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)

3. (a) PRINT FULL NAME Roberta Bohon

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

4. Sex Female 5. Color or race col 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife A R. Bohon 6. (c) Age of husband or wife if alive 80 years
 7. Birth date of deceased 12 25 1862
 (Month) (Day) (Year)

8. AGE: Years 77 Months 9 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____
 MOTHER FATHER { 12. Name Pete Campbell
 13. Birthplace mo
 (City, town, or county) (State or foreign country)
 14. Maiden name Margaret Campbell
 15. Birthplace mo
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature A R Bohon
 (b) Address 208 N 8th St

17. (a) Burial (b) Date thereof 2 17 - 40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Robinson Cem
 18. (a) Signature of funeral director Geo E Roberts
 (b) Address Hannibal mo

19. (a) 2-28-40 (b) J C Fisher
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Marion
 (c) City or town Hannibal mo
 (If outside city or town limits, write "RURAL")
 (d) Street No. 208 N 8th
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 13
 year 1940 hour 9 P.M. minute _____ M.
 21. I hereby certify that I attended the deceased from Jan 31
40 to Feb 13 1940
 that I last saw her alive on Feb 13 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Influenza Duration _____

Due to _____
 Due to _____
 Other conditions _____
 (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) _____
 While at work? at work Means of injury _____
 23. Signature A W Fox (M. D. or other) !
 Address Hannibal mo Date signed _____

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 with the above constitutes grounds for revocation of license.)

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7363

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 76

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:

(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)

3. (a) PRINT FULL NAME Roberta Bohon

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

4. Sex 7 5. Color or race cal 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased 12 25 186
(Month) (Day) (Year)

8. AGE: Years 97 ~~98~~ Months 1 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) March 11, 1940 (b) Wm. Lucke
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years

DECLARATION OF DEATH

20. DATE OF DEATH: Month Feb day 13 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

Duration

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 A. W. Foy (M. D. or other) _____

Address Hannibal Mo Date signed _____

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

SUPPLEMENTAL

