

No. 2
-11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

18972

State File No. _____

Registration District No. 547

Primary Registration District No. 8029

Registrar's No. 148

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

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

8. (a) PRINT FULL NAME Cecile Fayette 3011
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Chas. F 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Sept. 23 1882
(Month) (Day) (Year)

8. AGE: Years 57 Months 7 Days 4 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Joseph Chauvart
13. Birthplace Canada
(City, town, or county) (State or foreign country)
14. Maiden name Claudia Diava
15. Birthplace Canada
(City, town, or county) (State or foreign country)

16. (a) Informant Chas. Fayette
(b) Address 210 S 10th Hannibal Mo

17. (a) Burial (b) Date thereof April 29-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St Marys Cem.

18. (a) Signature of funeral director J. J. O'Connell
(b) Address Hannibal Mo

19. (a) May 10 40 (b) H. C. Fisher
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion
(c) City or town Hannibal
(If outside city or town limits, write "RURAL")
(d) Street No. 210 S 10th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27
year 1940 hour 7:20 minute 9 M.

21. I hereby certify that I attended the deceased from Apr 27 1940 to Apr 27 1940
that I last saw her alive on Apr 27 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Haemorrhage
Due to Hypertension

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

Major findings:
Of operations _____
Of autopsy _____

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? 4/27
(Specify type of place) (e) Means of injury _____

23. Signature H. C. Fisher (M. D. or _____)
Address Hannibal Mo Date signed May 10 40

Duration
? 6 hrs
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 Michael J. Hannibal
Licensed Embalmer No. 3246
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, above space should be left blank.