

Registration District No. 547

Primary Registration District No. 3029

Registrar's No.

193

1. PLACE OF DEATH:  
(a) County Marion  
(b) City or town Hannibal  
(c) Name of hospital or institution:  
115 South Sixth St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution not in hospital  
In this community entire life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri County Marion  
(c) City or town Hannibal  
(If outside city or town limits, write "RURAL")  
(d) Street No. 115 South Sixth  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Eleanor Hawkins Sargent  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month June day 27  
year 1940 hour 8:40 minute \_\_\_\_\_ M.

4. Sex Female 5. Color of race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife A. N. Sargent  
6. (c) Age of husband or wife if alive 76 years  
7. Birth date of deceased June 23, 1863  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan-1-40 to June 27, 1940  
that I last saw him alive on June 27, 1940  
and that death occurred on the date and hour stated above.  
Immediate cause of death Cerebral Arteriosclerosis  
Partial Paralysis of right side.

8. AGE: Years 77 Months — Days 4  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to She has had a hypertension of systolic B.P. 240 mm  
Due to for 15 yrs.

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation at home  
11. Industry or business \_\_\_\_\_  
12. Name Edwin J. Hawkins  
13. Birthplace Paris, Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name Martha Bates  
15. Birthplace Hannibal Missouri  
(City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Martha Bawell  
(b) Address Columbia, Missouri  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29, 1940  
(Month) (Day) (Year)  
(c) Place: burial or cremation Reverend Cemetery  
18. (a) Signature of funeral director Ray P. Schumaker  
(b) Address Hannibal, Mo.  
19. (a) June 28, 1940 (b) H. C. Fisher  
(Date received local registrar) (Registrar's signature)

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? Yes  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature H. B. Hobbs (M. D. or other) \_\_\_\_\_  
Address Hannibal Mo Date signed 4/28/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
MARGIN RESERVED FOR BINDING  
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.

FORM 5-17-39  
REV. 5-17-39  
U.S. GOVERNMENT PRINTING OFFICE

42R

SEP 4 1941

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.....

*Ray P. Schwartz*, Registered Apprentice No.....  
working under my personal supervision.

Signed *Ray P. Schwartz*

Licensee No. *17650*

P. O. Address *Stamford, Conn.*

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. **22273**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **547**

Primary Registration District No. **3029**

Registrar's No. ....

ROWENA MUOKE

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

1. PLACE OF DEATH:

(a) County **Marion**  
(b) City or town **Hammill**  
(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 \_\_\_\_\_ (Specify whether  
years, months or days)

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.

3. (a) PRINT FULL NAME **Eleanor Hawkins Sargent**

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **June** day **27**  
year **1946** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

4. Sex **F** 5. Color or race **W** 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 (Month) (Day) (Year)

8. AGE: Years **79** Months **-** Days **4** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_ (City, town, or county) (State or foreign country)

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) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Arteriosclerosis, Sclerotic Partial Paralysis**

Due to **right side**

Due to **Bulbar Paralysis** (1 yr.)

Other conditions **Hypertension**

(Include pregnancy within 6 months of death)

Major findings: **B. P. 140 mm for 1 yr.**

Of operations \_\_\_\_\_

Of autopsy **81W**

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 **H. B. Norton** (M. D. or other) \_\_\_\_\_  
Address **Hammill** Date signed **Aug-3-40**

SUPPLEMENTARY

