

NOV 20 1940

Registration District No. **577**

Primary Registration District No. **3079**

Registrar's No. **303**

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

4  
1  
5

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: Levering Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

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. 116 20th  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 19  
year 1940 hour 5 minute 25 A.

21. I hereby certify that I attended the deceased from Sept 10 to Oct 19 1940  
that I last saw her alive on 10-19 1940  
and that death occurred on the date and hour stated above

Immediate cause of death Cancer of Bladder  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Major findings: Cancer of Bladder  
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? Yes (Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_

23. Signature H. P. Bremer (M. D. or \_\_\_\_\_)  
Address Hannibal Mo Date signed 10-19-40

3. (a) PRINT FULL NAME Roberta Fisher Riney

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 Joseph M. Riney 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased March 21 1869  
(Month) (Day) (Year)

8. AGE: Years 71 Months 6 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mexico Andrain Cty. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business XX

12. Name Thomas H. Fisher

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

14. Maiden name Lucinda Catron

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

16. (a) Informant J. M. Riney

(b) Address 116 20th

17. (a) Burial (b) Date thereof 10/20/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cem.

18. (a) Signature of funeral director Wm. M. Smith

(b) Address 902 Broadway Hannibal Mo

19. (a) Oct 22 40 (b) H. C. Fisher  
(Date received local registrar) (Registrar's signature)

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**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 Joseph J. Marsh

Licensed Embalmer No. 3932

P. O. Address Hannibal Missouri

**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.**