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MOISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

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STANDARD CERTIFICATE OF DEATH

15144

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 15144

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 113114

1. PLACE OF DEATH:  
(a) County Marion  
(b) City or town Hannibal  
(c) Name of hospital or institution: Levering Hospital  
(d) Length of stay: In hospital or institution 2 weeks  
In this community Entire life

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Marion  
(c) City or town Hannibal  
(d) Street No. 2309 Chestnut  
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME Thelma Lucile Parnal

8. (b) If veteran, name war \_\_\_\_\_ 8. (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 Verl L. Parnal 6. (c) Age of husband or wife if alive 41 years  
7. Birth date of deceased September 3 1908

8. AGE: Years 32 Months 6 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Hannibal Missouri

10. Usual occupation At home

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

12. Name Edgar L. Young  
13. Birthplace Newtown North Carolina  
14. Maiden name Doris M. Snyder  
15. Birthplace Monroe County, Missouri

16. (a) Informant Verl L. Parnal

(b) Address Hannibal, Missouri

17. (a) Burial (b) Date thereof April 4, 1941  
(c) Place: burial or cremation Grand View Burial Park

18. (a) Signature of funeral director Roy P. Schwartz  
(b) Address Hannibal, Missouri

19. April 3, 1941 (b) W. P. Fisher

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 2nd year 1941 hour 12 minute 15 P. M.  
21. I hereby certify that I attended the deceased from 3/19/41 to 4/2/41 and that I last saw her alive on 4/2/41

Immediate cause of death: Staphylococcus Septicemia Regenerative Anemia Hypostatic Pneumonia  
Due to: Staphylococcus pneumoniae Blood Cultures  
Other conditions: Pregnancy 2nd trimester

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? \_\_\_\_\_  
(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 W. P. Fisher (M. D. or other) M.D.  
Address Hannibal Mo Date signed 4/3/41

Duration  
3 wks  
15 yrs  
2 days  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

9/12/50

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*

Licensed Embalmer No.

*1765*

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.

Registration District No. 547

Primary Registration District No. 3029

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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Helma Lucile Darnell

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

4. Sex 7 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 \_\_\_\_\_ year \_\_\_\_\_

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 32 Months 6 Days 29 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)

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) Citizen of foreign country \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month apr day 2 year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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 Staphylococcus Dysent

Sepsis

Vegetative Endocarditis

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

Due to Staphylococcus present in blood culture

Other conditions Pregnancy 2-30 gestation (include pregnancy within 3 months of death)

Major findings: Of operations Not performed - NO abortion -

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? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature W. E. Guthman (M. D. or other) MD

Address Hannibal Mo Date signed 4/2/48

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

SUPPLEMENTARY

