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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED AUG 12 1942

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 168

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's Hospital
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion ⁶⁴
(c) City or town Painyva ⁰
(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.? 1 years.

3. (a) PRINT FULL NAME Ellen A. Fox Evercooren

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, W. I. Div.

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

7. Birth date of deceased December 20 1871
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 6 17 hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Benedict Lilly

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

14. Maiden name Isabelle Leake

15. Birthplace Palls County MO
(City, town, or county) (State or foreign country)

16. (a) Informant Robert H. Evercooren

(b) Address Painyva, MO

17. (a) Burial (b) Date thereof June 30 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cem.

18. (a) Signature of funeral director James O'Connell

(b) Address Hannibal, MO
(c) 7/1/42 (d) H. W. Connor
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27
year 1942 hour _____ minute 6:05 P.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 Myocarditis
due to
phlebotomy
due to
phlebotomy
Other conditions Biloppyelitis
(Include pregnancy within 3 months of death)

Duration

Major findings:
Of operations none
Of autopsy none

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 J. H. Revell (M. D. or other) _____
Address 1011 S. Main St. Hannibal, MO Date signed 7/1/42

MOTHER FATHER

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

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. Howell

Licensed Embalmer No. *3246*

P. O. Address..... *Hennipah Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24772

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Maryland
(b) City or town Hammond
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Elizabeth
(If not in hospital or institution, give 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 Ellen A. Van Evercooren
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 W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 28 18
(Month) (Day) (Year)

8. AGE: Years 70 Months 6 Days mo (If less than one day, in min.)
9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry of business _____
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 _____
(Burial, cremation, or removal) (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 Dec Day 28 Year 1942 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: myocarditis
toxic

Due to pneumonia
Due to (Pneumococcus non tuberculous)
Other conditions (include pregnancy within 3 months of death) _____
Major findings: none 108
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? _____

(Specify type of place)
While at work _____ (c) Means of injury _____
23. Signature J. J. [unclear] (M. D. or other) _____
Address 1001 [unclear] Date signed 8/29/42

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



