

17-39  
X29484

FILED JUN 22 1943

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 128

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:  
LEYERING 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 MO. (b) County MARION  
(c) City or town HANNIBAL  
(If outside city or town limits, write "RURAL")  
(d) Street No. Nurses Home LEYERING HOSPT.  
(If rural, give location)  
(e) Citizen of foreign country?  (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MIMA VIRGINIA DASHNER

3. (b) If veteran, name war  3. (c) Social Security No. 500-20-0630

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased FEB. 16 1879  
(Month) (Day) (Year)

8. AGE: Years 64 Months 2 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation NURSE

11. Industry or business \_\_\_\_\_  
12. Name JOHN J. DASHNER

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

14. Maiden name MARGRET MILLER  
15. Birthplace W. VA.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. M. V. Selley

(b) Address SANTA FE, MO

17. (a) BURIAL (b) Date thereof Apr. 29 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SANTA FE, MO.

18. (a) Signature of funeral director Speed & Selley  
(b) Address PARIS, MO.

19. (a) 5/7/43 (b) M. L. Connor  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 26 year 1943 hour 11:45 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from April 4 1943 to \_\_\_\_\_ 1943;

that I last saw her alive on 4-26 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 3 hrs.

Due to Coronary sclerosis 2 yrs.

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

Other conditions Cholecystectomy  
(Include pregnancy within 3 months of death) (4-4-43)

Major findings: 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 \_\_\_\_\_ (Specify type of place) (r) Means of injury \_\_\_\_\_

23. Signature Harold Suedel (M. D. or other) MD.

Address Hannibal Mo. Date signed 4-29-43

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

MOTHER FATHER

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.....

Licensed Embalmer No. *2616*

P. O. Address..... *Louis, 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, fact should be so stated above.

*3/1/78*

Registration District No. 209

Primary Registration District No. 8043

Registrar's No. 128

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: Leveing Hospital  
(If not in hospital or institution, write street number & 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 \_\_\_\_\_ (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 \_\_\_\_\_

3. (a) PRINT FULL NAME Mima Virginia Deakner

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

4. Sex F 5. Color or race M 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb 16  
(Month) (Day) (Year)

8. AGE: Years 64 Months 2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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

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

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

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

14. Maiden name \_\_\_\_\_ (State or foreign country)

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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1943 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death coronary thrombosis Duration 3 hr

Due to coronary sclerosis 2 yrs.

Due to \_\_\_\_\_ 126

Other conditions chela cystitis  
(Include pregnancy within 3 months of death)

Major findings: 4-9-43 chela cystitis with stones

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 Arnold J. ... (M.D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTAL

S-21941