

BUREAU OF THE CENSUS  
FILED DEC 6 1943

State File No.

Registration District No. 208

Primary Registration District No. 43205761

Registrar's No. 56

## 1. PLACE OF DEATH:

(a) County Marion  
 (b) City or town Palmyra Hannibal Hannibal  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 Infirmary 5  
 (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)

3. (a) PRINT FULL NAME Richard E. Tomer

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife Carrie C. Farenhorst 6. (c) Age of husband or wife if alive, years

7. Birth date of deceased October 6, 1864  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
79 25 hr. min.9. Birthplace Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation Painter Retired

## 11. Industry or business

MOTHER FATHER

12. Name Isaac Tomer

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

14. Maiden name Charlotte Greenleaf

15. Birthplace Portland Maine  
(City, town, or county) (State or foreign country)16. (a) Informant Mrs. Alicia Rosser  
(b) Address Rendlen Avenue Hannibal Mo17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/43  
(Month) (Day) (Year)

(c) Place: burial or cremation Riverside Cemetery

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

(b) Address 902 Broadway Hannibal Mo

19. (a) 11/2/43 (b) Mrs. Margaret Maddox  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion 64  
 (c) City or town Palmyra  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Infirmary  
 (If rural, give location)  
 (e) Citizen of foreign country? (Yes or No)  
 If yes, name country.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 31  
year 1943 hour about & 7 minute 00 A. M.21. I hereby certify that I attended the deceased from Oct 29 1943 to Oct 31 1943  
that I last saw him alive on Oct 29 1943  
and that death occurred on the date and hour stated above.Immediate cause of death Arterio Sclerosis  
Duration 10yr.

Due to

Due to

Other conditions Chronic nephritis 2yr.  
(Include pregnancy within 3 months of death)Major findings: Of operations 1318  
PHYSICIAN

Of autopsy 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) Means of injury

23. Signature E. M. Lurie (M. D. or other)  
Address Hannibal Mo Date signed Nov 2 1943

**STATEMENT BY LICENSED EMBALMER**

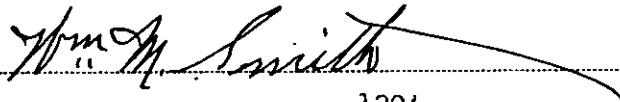
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

George T. Bond

Registered Apprentice No. 350

working under my personal supervision.

Signed.....



Licensed Embalmer No. 1204

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, fact should be so stated above.**

Registration District No. 208 Primary Registration District No. (5761)

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

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Infirmary  
(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

3. (a) PRINT FULL NAME Richard E. Jomer

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced n

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Oct (Month) 6 (Day) 1943 (Year)

8. AGE: Years 79 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day, \_\_\_\_\_ 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 \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (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 Oct year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

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

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

Other conditions (Include pregnancy within 3 months of death)

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 \_\_\_\_\_

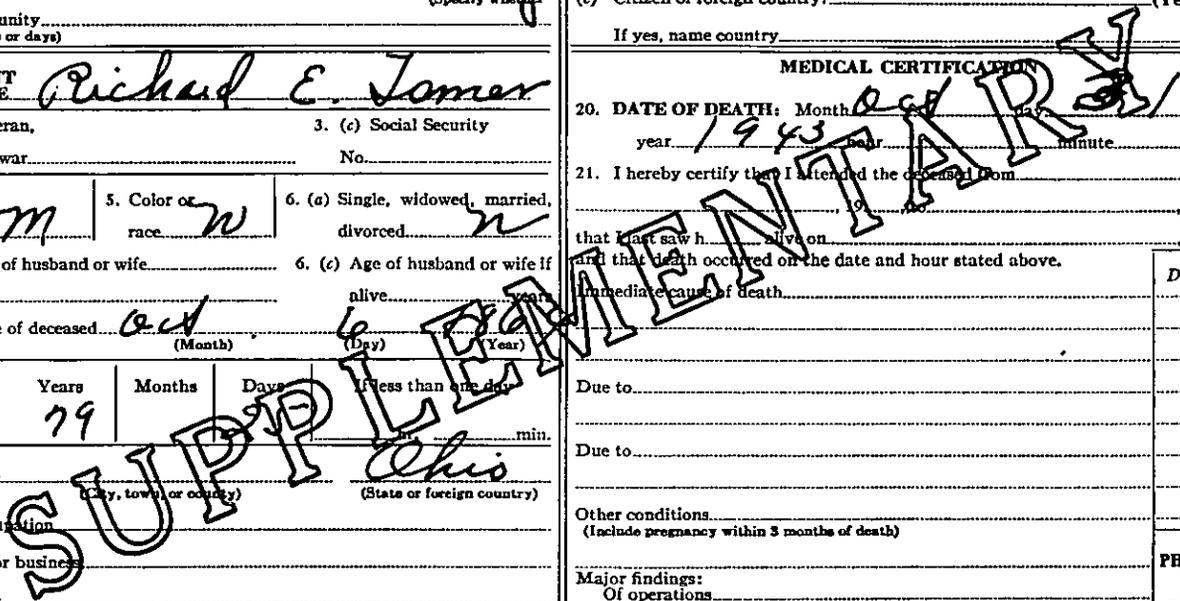
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

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



38695