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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

10106

**FILED** APR 6 1946 **STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 109

**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 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  
(c) City or town Hannibal  
(If outside city or town limits, write "RURAL")  
(d) Street No. Long's Rest Home  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME**

Martha Matilde Taylor

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, Widowed

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

7. Birth date of deceased June 20, 1859  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>8</u>	<u>12</u>	hr. _____ min. _____

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

10. Usual occupation XX

11. Industry or business XX

12. Name Charles Kinner

13. Birthplace No record  
(City, town, or county) (State or foreign country)

14. Maiden name McAdams

15. Birthplace No record  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Greer

(b) Address Sacramento California

17. (a) Burial (b) Date thereof 7/8/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Olivet

18. (a) Signature of funeral director Crawford Smith

(b) Address 902 Broadview Hannibal

19. (a) 3/12/46 (b) Dr. C. M. Lucke  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 2  
year 1946 hour 10 minute 25 A. M.

21. I hereby certify that I attended the deceased from March 1-46  
19\_\_\_\_, to March 2 1946  
that I last saw h. in alive on March 2 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia

Due to PT had been bedfast for 2 months

Due to following fractured hip

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy None performed

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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? \_\_\_\_\_

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

23. Signature B. P. L. Bede (M. D. or other) MD  
Address B. P. L. Bede Date signed 3-12-46

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 *Garford Smith*  
Licensed Embalmer No.....2814.....

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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
Registrar's No. 109

Registration District No. 209

Primary Registration District No. 3043

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 \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Martha M. Taylor

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 wid

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

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

8. AGE: Years 86 Months \_\_\_\_\_ Days \_\_\_\_\_ (Unless less than one day) hr. \_\_\_\_\_ 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 \_\_\_\_\_

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

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

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

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

(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 \_\_\_\_\_ year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 1946, that I last saw him alive on Mar. 1 and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to Lobar pneumonia Duration 3 d.

Due to fracture left femur 1 1/2 mo.

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. ADDITIONAL INFORMATION

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident 4 ft c

(b) Date of occurrence 1-18-46

(c) Where did injury occur? Darwood, Marion, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? fall on street (market) (Specify type of place)

While at work? no (e) Means of injury turned around + fell

23. Signature B L Murphy (M. D. or other)

Address Hannibal, Mo. Date signed 4-19-46

9028 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

10106