

No. 2
5-17-43
5-14-39
1 X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30956

Registration District No. 209 Primary Registration District No. 3043 State File No. _____ Registrar's No. 308

1. PLACE OF DEATH:
(a) County Maxion
(b) City or town Hannibal
(c) Name of hospital or institution:
623 Grand Ave 1
(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 Lucretia A Toy
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 Married
6. (b) Name of husband or wife FRANK 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased August 13 1906
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
40 1 14 hr. _____ min.

9. Birthplace Pike Co IL
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife

MOTHER FATHER
11. Industry or business _____
12. Name Barney Shellhorse
13. Birthplace IL
(City, town, or county) (State or foreign country)
14. Maiden name Delta Thomas
15. Birthplace IL
(City, town, or county) (State or foreign country)

16. (a) Informant Frank A Toy
(b) Address 623 Grand Hannibal Mo
17. (a) Burial (b) Date thereof 9-30-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation MT. Olive Cem
18. (a) Signature of funeral director James P. Koenig
(b) Address Hannibal Mo
19. (a) 9-30-46 (b) Dr. E. M. Lucke
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Maxion
(c) City or town Hannibal
(If outside city or town limits, write "RURAL")
(d) Street No. 623 Grand Ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 27
year 1946 hour _____ minute 9:50 P. M.
21. I hereby certify that I attended the deceased from 9-25
19 to 9-27 1946
that I last saw her alive on 9-27 1946
and that death occurred on the date and hour stated above.

Immediate cause of death internal hemorrhage Duration 48 hr.
Due to General Circumstances 27.
Due to Cerebral Hemip 27.
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
48A
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 0
23. Signature [Signature] (M. D. or other) _____
Address [Signature] Date signed 9-30-46

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

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FEB 5 1954

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 *H. M. O'Connell*
Licensed Embalmer No. 3889
P. O. Address *Stennel Me*

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.