

S. No. 2
1-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

30971

FILED OCT 8 1946 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 209

Primary Registration District No. 2043

Registrar's No. 310

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 Hosp. I
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 week
(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. 517 Church
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September 27
1946 year. 12 hour. 10 P minute. 8-1-43 M.
21. I hereby certify that I attended the deceased from _____, 19____, to 9-27-46, 19____;
that I last saw him alive on 9-27-46, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death. Cerebral hemorrhage

Duration
5 days

Due to Hypertensive cardio vascular disease 3 yrs.

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? _____

(Specify type of place)
While at work _____
23. Signature J. P. Dultzman (M. D. or other) MD.
Address Hannibal, Missouri Date signed _____

3. (a) PRINT FULL NAME Lee Owen Sweet

3. (b) If veteran, name war _____ 3. (c) Social Security No. 490-07-7513

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

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

7. Birth date of deceased December 31, 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>8</u>	<u>25</u>	hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business xx

12. Name Rensslear Sweet

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

14. Maiden name Mary M. Boyles

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

16. (a) Informant Mrs. E. C. Higgins

(b) Address Quincy Illinois

17. (a) Burial (b) Date thereof 9/20/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grandview Burial Park

18. (a) Signature of funeral director W. C. Smith

(b) Address 902 Broadway Hannibal Missouri

19. (a) 10-1-46 (b) Dr. E. M. Luelle
(Date received local registrar) (Registrar's signature)

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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.....*W. Crawford Smith*.....
Licensed Embalmer No.....*3814*.....

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.