S. No. 2
0M—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 24 1946

Registration District No. 209

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41332

Primary Registration District No. 3043

Registrar's No. 401

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: 1207 Owens Ave
(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 64

(c) City or town Hannibal 3
(If outside city or town limits, write "RURAL")

(d) Street No. 1207 Owens Ave 4
(If rural, give location) 0

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Flora Bell Clancy

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 Henry

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

7. Birth date of deceased February (Month) 17. (Day) 1874 (Year)

8. AGE: Years 67 | Months 9 | Days 8 | If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name George McClain
13. Birthplace — (City, town, or county) ILL (State or foreign country)

MOTHER
14. Maiden name Mary Anna Fry
15. Birthplace — (City, town, or county) ILL (State or foreign country)

16. (a) Informant Henry Clancy

(b) Address 1207 Owen ave. Hannibal Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 27. 1946 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cem

18. (a) Signature of funeral director James O'Donnell

(b) Address Hannibal Mo

19. (a) 12-20-46 (Date received local registrar) (b) Dr E M Lucke (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Nov. day 25 year 1946 hour ..... minute 2:15 P.M.

21. I hereby certify that I attended the deceased from 11-24, 1946, to 11-24, 1946 that I last saw her alive on 11.24, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration 24 hrs

Due to High Blood Pressure

Due to Arteriosclerosis

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations 83 A

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? ..... (e) Means of injury .....

23. Signature W P Birney (M. D. or other) M D

Address Hannibal Mo Date signed 11-27-46

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(Licensed Embalmer's Statement on Reverse Side)

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'Donnell

Licensed Embalmer No. 3889

P. O. Address Hammond Ind

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.