

FILED FEB 20 1947
Registration District No. 207

State File No.

Primary Registration District No. 3043

Registrar's No. 66

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: St. Elizabeth Hosp.
(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 Mrs. Martha Waddle

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

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

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

7. Birth date of deceased. November 2, 1905
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
41 2 29 hr. min.

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

10. Usual occupation.....
11. Industry or business International Shoe Factory

MOTHER FATHER

12. Name ~~No record~~ James Head

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

14. Maiden name ~~No record~~ Vera Judson

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

16. (a) Informant From Hospital Hubrey Head

(b) Address.....

17. (a) Burial (b) Date thereof 2/2/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hill Mo. Hannibal Missouri

18. (a) Signature of funeral director W. E. Smith
(b) Address 902 Broadway Hannibal Missouri

19. (a) 2-4-47 (b) Dr. E. M. Ducke
(Date received local registrar) (Registrar's signature)

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. 705 South Main
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 31 year 1947 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan 29 1947 to Jan 31 1947
that I last saw her alive on Jan 31 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Duration.....

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Due to.....

Due to.....

Other conditions respirate
(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?

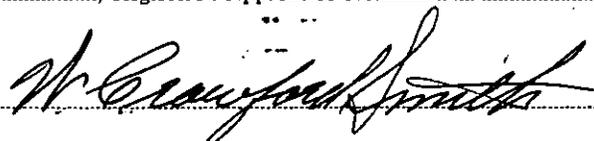
While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature J. H. [unclear] (M. D. or other).....
Address 101 Baymond St. Date signed.....

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 

Licensed Embalmer No. 3814

..... P. O. 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. March

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Hammond
(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 Waddle
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 Widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov. 2, 1903
(Month) (Day) (Year)

8. AGE: 41 Years Months Days (If less than one day, hr. min.)
9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____

MOTHER { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(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 _____

20. DATE OF DEATH: Month _____ Year 1941 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____
Myocardial Infarct. (Chronic)

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Hepatitis

Major findings: _____
Of operations _____
Of autopsy _____

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 _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-5477