

FILED APR 9 1947

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 126

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Hannibal
(c) Name of hospital or institution: Leveering 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 Mo (b) County Marion
(c) City or town Hannibal
(If outside city or town limits, write "RURAL")
(d) Street No. 1219 Lindell Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Aida Smith

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

4. Sex Female Color or race Negro
6. (a) Single, widowed, married, divorced widowed
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: (Month) _____ (Day) 1879 (Year) _____

8. AGE: Years about 68 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Marion Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Domestic

MOTHER FATHER

11. Industry or business _____
12. Name John Gordon
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 John Vaughn
(b) Address ST Louis

17. (a) Burial (b) Date thereof 3-22-47
(Burial, cremation, etc.) (Month) (Day) (Year)

(c) Place: burial or cremation Robinson Cemetery

18. (a) Signature of funeral director Geo E Roberts

(b) Address Hannibal Mo

19. (a) 3-28-47 (b) Dr E M Lucke
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 19
year 1947 hour 10 minute 30 AM

21. I hereby certify that I attended the deceased from 2
2-15, 1947, to 3-19, 1947
that I last saw her alive on 3-19, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration _____

Due to Cerebral Hemorrhage

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? _____

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

23. Signature [Signature] (M. D. or other) _____
Address 1216 Center, Hannibal Mo Date signed 3-27-47

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 Geo E Roberts
Licensed Embalmer No. 2113
P. O. Address Hannibal Mo

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.