

No. 2  
-12-45  
5-17-39  
1-547070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAR 21 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **9988**  
Registrar's No. **90**

Registration District No. **209**

Primary Registration District No. **3042**

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

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 Hospital**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....  
(Specify whether years, months or days)

In this community.....  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **GEORGIA A. STOLTE**

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 **Widowed**

6. (b) Name of husband or wife **Anton**

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

7. Birth date of deceased **July 13 1876**  
(Month) (Day) (Year)

|         |       |        |      |                      |
|---------|-------|--------|------|----------------------|
| 8. AGE: | Years | Months | Days | If less than one day |
|         | 70    | 6      | 14   | ..... hr. .... min.  |

9. Birthplace **Unknown** **9**  
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business **Housework**

MOTHER FATHER

12. Name **Dave Miller** **9**

13. Birthplace **Unknown** **9**  
(City, town, or county) (State or foreign country)

14. Maiden name **Anna L. Parker**

15. Birthplace **Unknown** **9**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Helen Stout**

(b) Address **Hannibal, Mo.**

17. (a) **Burial** (b) Date thereof **1/29/47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial of **Mt. Olivet Cemetery**

18. (a) Signature of funeral director **Jac. O'Connell**

(b) Address **Hannibal, Mo.**

19. (a) **3-7-47** (b) **Dr. E. M. Sucke**  
(Date received local registrar) (Registrar's signature)

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. **119 Shepherd Place** **4**  
(If rural, give location)

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

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** **27**  
year **1947** hour..... minute **145** **AM**

21. I hereby certify that I attended the deceased from **12-19 1946** to **1-27 1947**; that I last saw her alive on **1-26 1947**; and that death occurred on the date and hour stated above.

Immediate cause of death.....  
**Branch pneumonia** **2 days**

Due to **Cerebral Hemorrhage** **2 days**

Due to **Hypertensive Heart Disease** **1 year**

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

Major findings:  
Of operations..... **930**

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:

(c) 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)

Means of injury..... **0**

23. Signature **Harry L. Bruce** (M. D. or other)  
Address **Holmes Bldg., Hannibal, Mo** Date signed **2-27-47**

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**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..... *A. M. Williams*

Licensed Embalmer No. *3884*

P. O. Address..... *Hospital, Ill*

**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.**

Registration District No. 209 Primary Registration District No. 3043

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

**1. PLACE OF DEATH:**

(a) County Marion

(b) City or town Hamburg  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)

years, months or days

**3. (a) PRINT FULL NAME** Georgia A Stalte

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 wid

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

7. Birth date of deceased July 13 1913  
(Month) (Day) (Year)

**8. AGE:** Years 70 Months 6 Days \_\_\_\_\_ (If less than one day, hr. min.)

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

10. Usual occupation housewife

11. Industry or business none

**MOTHER FATHER**

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_ (City, town, or county) (State or foreign country)

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) Edmund Lusk  
(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 \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month \_\_\_\_\_ year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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