

FILED OCT 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31061

BIRTH NO. _____		REG. DIST. NO. 209		PRIMARY REG. DIST. NO. 2043		Registrar's No. 318			
1. PLACE OF DEATH a. COUNTY Marion				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Marion					
b. CITY (If outside corporate limits, write RURAL and give town) Hannibal		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) Hannibal		66			
d. FULL NAME OF HOSPITAL OR INSTITUTION 616 Hazel				d. STREET ADDRESS (If rural, give location) 616 Hazel St. 3d					
3. NAME OF DECEASED (Type or Print) a. (First) Bettie b. (Middle) Melvina c. (Last) King			4. DATE OF DEATH (Month) (Day) (Year) Aug. 31 1949						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Sept. 15, 1869		9. AGE (in years last birthday) 79			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME John Barker		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Charles					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME John King		ADDRESS Hannibal			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 3 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4500			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from July 1946 to Aug 31, 1949, that I last saw the deceased alive on Aug 29, 1949, and that death occurred Aug 31, 1949 from the causes and on the date stated above.									
23a. SIGNATURE Glenn R. Miller D.O.				23b. ADDRESS Hannibal Mo.		23c. DATE SIGNED 8/27/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8/16/49		24c. NAME OF CEMETERY OR CREMATORY Mt. Olive		24d. LOCATION (City, town, or county) Hannibal Mo.			
DATE REC'D BY LOCAL REG. 9-24-49		REGISTRAR'S SIGNATURE W. E. M. Lucke		FUNERAL DIRECTOR'S SIGNATURE James O'Donnell		ADDRESS Hannibal			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

Student Embalmer No.

working under my personal supervision.

Signed.....

Michael J. O'Donnell

Licensed Embalmer No. 3246

Signed.....

Student Embalmer

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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