

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34416**  
Registrar's No. **345**

FILED OCT 26 1949

BIRTH NO. _____		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>3043</u>		Registrar's No. <u>345</u>	
1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hannibal</u>		c. LENGTH OF STAY (in this place) <u>0</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hannibal</u>		d. STREET ADDRESS (If rural, give location) <u>1929 Market St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. Elizabeth Hospital</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>Lowell</u> b. (Middle) <u>Eugene</u> c. (Last) <u>Tallman</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>October 6, 1949</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>August 6, 1933</u>	
9. AGE (In years last birthday) <u>17</u>		if UNDER 1 YEAR <u>2</u> Months		if UNDER 1 HRS. <u>—</u> Hours		if UNDER 4 HRS. <u>—</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Highway Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Highway Dept</u>		11. BIRTHPLACE (State or foreign country) <u>Hannibal Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Lowell Tallman</u>		13b. MOTHER'S MAIDEN NAME <u>Sylvia Tankley</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Lowell Tallman</u> ADDRESS <u>1929 Market Hannibal Mo</u>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Retrocranial Surgery</u>  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. <u>Inquest pending</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Approx 8 hrs</u>  <u>ES 124</u> <u>25</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway 26</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Monroe County - Mo.</u> <u>Mo.</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (P. M.) <u>10-6-49</u> <u>4:00 P. M.</u>	
		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Struck by automobile</u>			
22. I hereby certify that I attended the deceased from <u>Oct 6, 1949</u> , to <u>Oct 6, 1949</u> , that I last saw the deceased alive on <u>Oct 6, 1949</u> , and that death occurred at <u>11:22 P. M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. J. Murphy M.D.</u>				23b. ADDRESS <u>103 N. 6th Hannibal Mo</u>		23c. DATE SIGNED <u>10/11/49</u>	
24a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10-10-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MT. Olive Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Hannibal Marion Mo</u>	
DATE REC'D BY LOCAL REG. <u>10-14-49</u>		REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James O'Donnell</u>		ADDRESS <u>Hannibal Mo</u>	

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

64  
34

RECEIVED OCT 22 1949  
MARION CO. HEALTH DEPT,  
DATE FILED OCT 25 1949

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.

Student \_\_\_\_\_  
Student Embalmer

Signed Michael J. Cofford

Licensed Embalmer No. 3246

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.