

U.S. No. 300
REV. 10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37949

State File No. _____

FILED NOV 28 1949

1. PLACE OF DEATH
 a. COUNTY Marion
 b. CITY OR TOWN Hannibal
 c. LENGTH OF STAY (in this place)
 d. FULL NAME OF HOSPITAL OR INSTITUTION Lovering Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
 a. STATE Missouri b. COUNTY Marion
 c. CITY OR TOWN Hannibal
 d. STREET ADDRESS 500 E 14 ST

3. NAME OF DECEASED
 a. (First) Elizabeth b. (Middle) — c. (Last) Bolin

4. DATE OF DEATH (Month) (Day) (Year)
NOV. 9 - 1949

5. SEX Female **6. COLOR OR RACE** White **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** Married **8. DATE OF BIRTH** June 12, 1866 **9. AGE** (In years last birthday) 83 **IF UNDER 1 YEAR** (Month) (Day) (Year) 4 28 **IF UNDER 1 HR.** (Hour) (Min.) —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired **10b. KIND OF BUSINESS OR INDUSTRY** ILL **11. BIRTHPLACE** (State or foreign country) ILL **12. CITIZEN OF WHAT COUNTRY?** USA

13a. FATHER'S NAME Henry Cobe **13b. MOTHER'S MAIDEN NAME** Margaret David **14. NAME OF HUSBAND OR WIFE** William

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No **16. SOCIAL SECURITY NO.** — **17. INFORMANT'S SIGNATURE OR NAME** William Bolin **ADDRESS** 500 E 14 St Hannibal MO

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, asphyxia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia
 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 4 days

19a. DATE OF OPERATION **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** YES NO

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) **21e. INJURY OCCURRED WHILE AT WORK** **NOT WHILE AT WORK** **21f. HOW DID INJURY OCCUR?**

22. I hereby certify that I attended the deceased from Nov. 6, 1949, to Nov. 9, 1949, that I last saw the deceased alive on Nov. 9, 1949, and that death occurred at 11:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) B. J. Mung **23b. ADDRESS** Hannibal, Mo. **23c. DATE SIGNED** 11-11-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial **24b. DATE** 11-11-49 **24c. NAME OF CEMETERY OR CREMATORY** New Center Cemetery **24d. LOCATION** (City, town, or county) (State) New Center, ILL

DATE REC'D BY LOCAL REG. 11-16-49 **REGISTRAR'S SIGNATURE** B. J. Mung **25. FUNERAL DIRECTOR'S SIGNATURE** James Adameel **ADDRESS** Hannibal MO

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

RECEIVED NOV 22 1949
HEALTH DEPT.
DATE FILED NOV 26 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. O'Connell

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.