

FILED OCT 30 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34123

BIRTH NO. _____		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>3043</u>		Registrar's No. <u>359</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)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hannibal</u> <u>0640</u>												
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. Elizabeth Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>P. O. D. U.S. Highway, 36 West</u>												
3. NAME OF DECEASED (Type or Print) a. (First) <u>Howard</u>			b. (Middle) <u>J.</u>		c. (Last) <u>Hirner</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>October 12, 1950</u>									
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept. 6, 1905</u>		9. AGE (In years last birthday) <u>45</u>	<table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 1 MONTH</td> <td>IF UNDER 1 WEEK</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> </tr> <tr> <td><u>1</u></td> <td><u>6</u></td> <td><u>0</u></td> </tr> </table>	IF UNDER 1 YEAR	IF UNDER 1 MONTH	IF UNDER 1 WEEK	Months	Days	Hours	<u>1</u>	<u>6</u>	<u>0</u>
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Months	Days	Hours														
<u>1</u>	<u>6</u>	<u>0</u>														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Palmyra, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13a. FATHER'S NAME <u>Joseph Hirner</u>			13b. MOTHER'S MAIDEN NAME <u>Sophia Kroeger</u>		14. NAME OF HUSBAND OR WIFE <u>Margaret</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Margaret Hirner P. O. D. Hannibal Mo</u>			ADDRESS									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH									
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Metastatic Carcinoma</u>				ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. DUE TO (b) <u>Carcinoma of Colon</u> DUE TO (c)			June-1948									
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							<u>1537</u>									
19a. DATE OF OPERATION <u>8-2-50</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Colon re-sected</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
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 <u>June</u> , 19 <u>48</u> , to <u>October</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Oct. 12, 1950</u> , and that death occurred at <u>1:50 a. m.</u> , from the causes and on the date stated above.																
23a. SIGNATURE <u>A. J. ...</u> (Degree or title)				23b. ADDRESS <u>Hannibal, Mo.</u>		23c. DATE SIGNED <u>10-20-50</u>										
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10-14-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>ST. Marys Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Hannibal Marion Mo</u>											
DATE REC'D BY LOCAL REG. <u>10-21-50</u>		REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke</u>		FUNERAL DIRECTOR'S SIGNATURE <u>James O'Donnell</u>		ADDRESS <u>Hannibal Mo</u>										

(Licensed Emballer's Statement on Reverse Side)

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

RECEIVED OCT 26 1950
.. ARIZONA CO. HEALTH DEPT.
DATE FILED OCT 27 1950

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Michael J. O'Connell

Signed.....
Student Embalmer

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.