

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19361**

FILED JUN 17 1952

BIRTH NO. _____ REG. DIST. NO. 91 PRIMARY REG. DIST. NO. 4040 Registrar's No. 16

1. PLACE OF DEATH a. COUNTY Benton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Benton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cole Camp		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cole Camp	
c. LENGTH OF STAY (in this place) 14 yrs			
d. FULL NAME OF HOSPITAL OR INSTITUTION --		d. STREET ADDRESS (If rural, give location) --	

3. NAME OF DECEASED (Type or Print) a. (First) Hettie	b. (Middle) Jane	c. (Last) Hanrahan	4. DATE OF DEATH (Month) (Day) (Year) June 4th 1952
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 11th 1873	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months 1 Days 23	IF UNDER 48 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Missouri 0	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME J W Parks	13b. MOTHER'S MAIDEN NAME Fanny Berry	14. NAME OF HUSBAND OR WIFE Charles Hanrahan
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs George Riffle Cole Camp Mo
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage			10 hrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) arteriosclerosis DUE TO (c) Hypertension			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		10-12 yrs		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **June 3, 1952**, to **June 4, 1952**, that I last saw the deceased alive on **June 4, 1952**, and that death occurred at **12:25 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Name or title) Harold B. Wacker, D.O.	23b. ADDRESS London, Mo	23c. DATE SIGNED 6/6/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June 7th 1952	24c. NAME OF CEMETERY OR CREMATORY Union Cemetery	24d. LOCATION (City, town, or county) (State) Cole Camp Mo
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DATE REC'D BY LOCAL REG. June 6 1952	REGISTRAR'S SIGNATURE E L Eichhoff	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E L Eichhoff Cole Camp, Mo
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(License Embalmer's Statement on Reverse Side)

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

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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 _____

_____, Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed E. L. Eichhoff

Licensed Embalmer No. 730

P. O. Address Cole Camp 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.