

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

JAN 9 1953

BIRTH NO. _____ REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3043** Registrar's No. **1**

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

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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 township) Hannibal		c. CITY (If outside corporate limits, write RURAL and give township) Hannibal	
c. LENGTH OF STAY (In this place) 12/26/52		d. STREET ADDRESS (If rural, give location) 505 Walnut	
d. FULL NAME OF HOSPITAL OR INSTITUTION Levering Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Florence Mae b. (Middle) Bauer c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) January 1, 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH January 1, 1879	9. AGE (In years last birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pittsfield Illinois		12. CITIZEN OF WHAT COUNTRY? U S A	

13a. FATHER'S NAME Joe B. Adrian		13b. MOTHER'S MAIDEN NAME Mary McCann		14. NAME OF HUSBAND OR WIFE George Albert Bauer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XX (If yes, give war or dates of service) XX		16. SOCIAL SECURITY NO. XX		17. INFORMANT'S SIGNATURE OR NAME Mr. G. A. Bauer	
				ADDRESS 505 Walnut Hannibal Missouri	

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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal pneumonia		INTERVAL BETWEEN ONSET AND DEATH 2 days
		ANTECEDENT CAUSES DUE TO (b) myocardial failure		
		DUE TO (c) _____		
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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)		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 **12-26**, 19**52**, to **1-1-53**, 19**53**, that I last saw the deceased alive on **1-1-53**, 19**53**, and that death occurred at **5:08P** m., from the causes and on the date stated above.

23a. SIGNATURE J. E. Gultzman M.D.		23b. ADDRESS 115 North 5th St. Hannibal, Mo.		23c. DATE SIGNED 1-2-53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/3/53		24c. NAME OF CEMETERY OR CREMATORY Mount Olivet		24d. LOCATION (City, town, or county) (State) Hannibal Missouri	
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DATE REC'D BY LOCAL REG. 1-5-53		REGISTRAR'S SIGNATURE Dr. E. M. Lucke By W. C. Fisher		25. FUNERAL DIRECTOR'S SIGNATURE W. C. Crawford		ADDRESS Hannibal Missouri	
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RECEIVED JAN 8 1953
MARION CO. HEALTH DEPT.,
DATE FILED JAN 8 1953

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.....
Student Embalmer

Signed *H. C. Campbell Smith*.....

Licensed Embalmer No..... 3814

P. O. Address Hannibal Missouri.....

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.