

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18714

FILED JUN 15 1953

BIRTH NO. REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 2121

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 0644	
d. FULL NAME OF HOSPITAL OR INSTITUTION David's Rest Home		d. STREET ADDRESS (If rural, give location) 721 So. Main St., 0	

3. NAME OF DECEASED (Type or Print) a. (First) Lula Belle b. (Middle) Nolin c. (Last) Myers		4. DATE OF DEATH (Month) (Day) (Year) 6-3-53	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 10-6-1860
9. AGE (In years last birthday) 92		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Clark, Missouri
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Retired	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Thomas Stockton	13b. MOTHER'S MAIDEN NAME American Jacobs	14. NAME OF HUSBAND OR WIFE William Myers
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Harry Nolin, Quincy, Illinois

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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 week
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary heart failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis 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 4341	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.) Hannibal Marion Mo.	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 **8/4/52**, 19___, to **6/3/53**, 19___, that I last saw the deceased alive on **6/2/53**, 19___, and that death occurred at **10:55 P.**, from the cause and on the date stated above.

23a. SIGNATURE W. W. Schweigert M.D.	(Degree or title)	23b. ADDRESS 508 Broadway	23c. DATE SIGNED 6/5/53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6/6/53	24c. NAME OF CEMETERY OR CREMATORY Clark Cemetery	24d. LOCATION (City, town, or county) (State) Clark, Mo.

DATE REC'D BY LOCAL REG. 6/5/53	REGISTRAR'S SIGNATURE Dr. E. M. Lucke	25. FUNERAL DIRECTOR'S SIGNATURE Michael J. O'Connell	ADDRESS Hannibal Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED JUN 12 1953
MARION CO. HEALTH DEPT.
DATE FILED JUN 12 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Michael J. O'Donnell

Licensed Embalmer No. 3246

P. O. Address Harwood no

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.