

Conello

STANDARD CERTIFICATE OF DEATH

22184

State File No. _____

FILED JUL 9 - 1953 REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 243

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)		d. STREET ADDRESS (If rural, give location) 1709a Vernon St.,	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Elizabeth Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) K. c. (Last) Ator			4. DATE OF DEATH (Month) (Day) (Year) 7-1-53		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3/4/1869	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months 3 Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and State or Foreign Country) Illinois	12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Jacob Ator		13b. MOTHER'S MAIDEN NAME Martha Fast		14. NAME OF HUSBAND OR WIFE Nora Ator	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Mrs. Nora Ator ADDRESS 1709a Vernon 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 1 yr. 1 yr.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Diabetes			
		DUE TO (c) Bronchial Asthma			
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on **7**, 19____, and that death occurred at **11 A.** m., from the causes and on the date stated above.

23a. SIGNATURE Dr. E.M. Lucke (Degree or title)		23b. ADDRESS 707 Broadway		23c. DATE SIGNED 7/3/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7/3/53		24c. NAME OF CEMETERY OR CREMATORY Pleasant Hill	
24d. LOCATION (City, town, or county) (State) Pleasant Hill, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Michael J. O'Connell ADDRESS Hannibal, Mo.			
DATE REC'D BY LOCAL REG. 7-3-53		REGISTRAR'S SIGNATURE Dr. E.M. Lucke			

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

JUL 8 1953

RECEIVED

MARION CO. HEALTH DEPT.

DATE FILED JUL 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Michael J. O'Donnell

Licensed Embalmer No. 3246

P. O. Address Harrisonville

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.