

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 9 - 1953

BIRTH NO. _____ REG. DIST. NO. 109 PRIMARY REG. DIST. NO. 3043 Registrar's No. 289

1. PLACE OF DEATH a. COUNTY <u>Marion County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Shelby</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hannibal, Mo.</u>		c. LENGTH OF STAY (In this place) <u>6 days</u>	c. CITY OR TOWN <u>Shelbyville, Mo.</u> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Elizabeth Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>X</u> <u>1020</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>LORA</u>	b. (Middle) <u>FRANCIS</u>	c. (Last) <u>CHRISTINE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>6-28-1953</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>6-22-1953</u>	9. AGE (In years last birthday) <u>0</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>6</u>	IF UNDER 4 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Hannibal, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Earl Christine</u>	13b. MOTHER'S MAIDEN NAME <u>Myda Noble</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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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. <u>X</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Earl Christine, Shelbyville, Mo.</u>	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Unknown</u> ANTECEDENT CAUSES DUE TO (b) _____ 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 <u>7955</u>	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 6/22, 1953, to 6/28, 1953, that I last saw the deceased alive on 6/28, 1953, and that death occurred at 11:00 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>T. J. Hoerschler M.D.</u>	23b. ADDRESS <u>Shelbina Mo</u>	23c. DATE SIGNED <u>6-28-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	24b. DATE <u>6-29-1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F.</u>	24d. LOCATION (City, town, or county) (State) <u>Shelbina, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>6-30-53</u>	REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke by W. C. Fisher</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Barkelaw-Hawkins, Shelbina, Mo.</u>	ADDRESS
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RECEIVED JUL 8 1953
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.....
Signature of Student Embalmer

Signed..... *C. W. H. [Signature]*

Licensed Embalmer No. *3490*

P. O. Address *St Albans*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.