

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36522**

FILED **OCT 26 1953**

BIRTH NO. _____ REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3042** Registrar's No. **362**

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) OR TOWN Hannibal		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Elizabeth Hospital		d. STREET ADDRESS (If rural, give location) 601 Sycamore	

3. NAME OF DECEASED (Type or Print)	a. (First) Harry	b. (Middle)	c. (Last) Fessenden Jr.	4. DATE OF DEATH (Month) (Day) (Year) 10-20-1953
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Never Married	8. DATE OF BIRTH 10/19/1953	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min. 8
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Hannibal	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Harry Fessenden Sr.	13b. MOTHER'S MAIDEN NAME Frances Lambert	14. NAME OF HUSBAND OR WIFE - -
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Harry Fessenden, 601 Sycamore	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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature Infant		INTERVAL BETWEEN ONSET AND DEATH 1 day
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. (4 1/2 months gestation)		
	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	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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 **10/19/1953** to **10/20/1953**, that I last saw the deceased alive on **10/20/1953**, and that death occurred at **6:50 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Ruby Lanning M.D. Hannibal, Mo.	23b. ADDRESS	23c. DATE SIGNED 10/20/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/21/53	24c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	24d. LOCATION (City, town, or county) (State) Hannibal, Mo.
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DATE REC'D BY LOCAL REG. 10-21-53	REGISTRAR'S SIGNATURE Dr. C. M. ...	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 OCT 23 1953

MAHON CO. HEALTH DEPT.

DATE FILED OCT 23 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 Hennival 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.