

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19653

State File No. \_\_\_\_\_

FILED JUN 24 1954

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

BIRTH NO. _____		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>3043</u>		Registrar's No. <u>177</u>	
1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Hannibal</u> )		c. LENGTH OF STAY (In this place) <u>6/11/54</u>		c. CITY OR TOWN <u>Hannibal</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Levering Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>212 South Sixth</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Rosalie Green</u> b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH <u>June 13, 1954</u>		4. DATE (Month) (Day) (Year)		
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>October 14, 1872</u>		9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>29</u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Hannibal, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13a. FATHER'S NAME <u>Frank Green</u>		13b. MOTHER'S MAIDEN NAME <u>Rose</u>		14. NAME OF HUSBAND OR WIFE <u>Never married</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Frank Green</u> ADDRESS <u>Hannibal Missouri</u>			
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) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arterio sclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Anemia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>??</u> <u>2 days</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (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 <u>6/11/54</u> , 19 <u>54</u> , to <u>6/13/54</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>6/13/54</u> , 19 <u>54</u> and that death occurred at <u>11:58Pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Robert J. Lanning M.D.</u> (Degree or title)				23b. ADDRESS <u>Hannibal, Mo</u>		23c. DATE SIGNED <u>6/15/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6/17/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u>		24d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>		
DATE REC'D BY LOCAL REG. <u>6/16/54</u>		REGISTRAR'S SIGNATURE <u>W.C. Fisher Deputy 187</u>		25. GENERAL DIRECTOR'S SIGNATURE <u>H. Crawford Smith</u>		ADDRESS <u>Hannibal Missouri</u>	

RECEIVED JUN 22 1954  
MARION CO. HEALTH DEPT.  
DATE FILED JUN 22 1954

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 *H. Crawford Smith*.....

Licensed Embalmer No...3814...

P. O. Address..Hannibal..Miss

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.