

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34617

State File No. ....

No. 300  
10.48

*Am. Council*  
FILED NOV 12 1954  
97222-54

BIRTH NO. 97222-54 REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 328

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 township) OR TOWN <u>St. Hannibal Beth Hospital</u>		c. LENGTH OF STAY (in this place) <u>1</u>	c. CITY OR TOWN <u>Hannibal</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 HOSPITAL OR INSTITUTION <u>St. Elizabeth Hospital</u>			e. STREET ADDRESS (If rural, give location) <u>602 Rock St.,</u> <i>0647/0</i>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Lori</u> b. (Middle) <u>Gilbert</u> c. (Last) <u>Gilbert</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>10-22-54</u>		
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>10/22/54</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>7</u> IF UNDER 24 HRS. Days <u>1</u> MIN.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Hannibal, Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>John J. Gilbert</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Carolyn Elliott</u>	
14. NAME OF HUSBAND OR WIFE <u>---</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>John Gilbert, 602 Rock, Hannibal, Mo</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. INTERVAL BETWEEN ONSET AND DEATH <u>7 mo.</u>	

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Premature Infant</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 mo.</u>
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		
ANTECEDENT CAUSES		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
DUE TO (b) <u>Anencephalus with</u>		
DUE TO (c) <u>Craniorachischisis</u>		<u>7 mo.</u>
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>750 X</u>		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) (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>10-22-54</u> , 19 <u>54</u> , to <u>Oct. 22</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>Oct. 22</u> , 19 <u>54</u> , and that death occurred at <u>8:15P</u> m., from the causes and on the date stated above.					
23a. SIGNATURE <u>Jm Karulla M.D.</u> (Degree or title)		23b. ADDRESS <u>707 Bdwg</u>		23c. DATE SIGNED <u>11/1/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10/23/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>Hannibal, Mo.</u>	

DATE REC'D BY LOCAL REG. <u>11/1/54</u>		REGISTRAR'S SIGNATURE <u>Wm Lucke By H.C. Fisher</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H.M. O'Donnell - Hannibal Mo</u> ADDRESS	
---	--	--	--	--	--

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED NOV 9 1954  
MARION CO. HEALTH DEPT.  
DATE FILED NOV 9 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..... *M. M. O'Donnell*

Licensed Embalmer No. *3889*

P. O. Address... *Hannibal*

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.