

FILED NOV 1-2 1954

THE DIVISION OF HEALTH STANDARD CERTIFICATE OF DEATH

34636

State File No.

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 329

1. PLACE OF DEATH
a. COUNTY Madison

2. USUAL RESIDENCE (Where deceased lived. If designation: residence before admission).
a. STATE Missouri b. COUNTY Madison

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal, Mo.

c. CITY OR TOWN Hannibal

d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION Welcome Rest Home 414 Church St.

e. STREET ADDRESS (If rural, give location) 414 Church St.

3. NAME OF DECEASED
a. (First) John Henry b. (Middle) _____ c. (Last) Utterback

4. DATE OF DEATH (Month) (Day) (Year) 10-27-54

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH 2-29-1868

9. AGE (In years last birthday) 86 7 12 06 49 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (retired)

10b. KIND OF BUSINESS OR INDUSTRY Farm

11. BIRTHPLACE (City and State or Foreign Country) Ralls Co. Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME W. A. Utterback

13b. MOTHER'S MAIDEN NAME Frances Ann Scobee

14. NAME OF HUSBAND OR WIFE Georgia Ann Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Alta McGee Perry, Mo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac De-compensation

INTERVAL BETWEEN ONSET AND DEATH

*This does not mean the mode of dying, such as heart failure, asphyxia, 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) Senility
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS:
Conditions contributing to the death but not related to the disease or condition causing death. Prostatic hypertrophy & cystitis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION 4343

20. AUTOPSY? YES NO

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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 6, 1954, to Oct 27, 1954, that I last saw the deceased alive on 10/27, 1954, and that death occurred at 9:50 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Am. Buchanan M.D.

23b. ADDRESS Hannibal, Missouri

23c. DATE SIGNED 10/30/54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10-31-1954

24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery

24d. LOCATION (City, town, or county) (State) Ralls County, Missouri

DATE REC'D BY LOCAL REG. 11/1/54

REGISTRAR'S SIGNATURE N. E. M. Locke Reg. H. C. F. Fike

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Clayton C. Walker Perry Mo

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

RECEIVED NOV 9 1954

ARKANSAS 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..... *Clyde C. Wisney*

Licensed Embalmer No. *38*

P. O. Address..... *Parry*

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.