

FILED DEC 27 1954

## STANDARD CERTIFICATE OF DEATH

41723  
State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>3043</u>		Registrar's No. <u>389</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>Marion</u>		b. CITY (If outside corporate limits, write RURAL and give town(ship)) <u>Hannibal</u>		a. STATE <u>Ill.</u>		b. COUNTY <u>Pike</u>	
c. LENGTH OF STAY (in this place) <u>12 Days</u>		c. CITY (If outside corporate limits, write RURAL and give town(ship)) <u>New Canton, Ill.</u>		d. STREET ADDRESS <u>None</u>		<u>8120</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Becky Thatcher Nursing Home</u>				d. STREET ADDRESS (If rural, give location) <u>None</u>			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH				
a. (First) <u>Edith</u>		b. (Middle) <u>Mae</u>	c. (Last) <u>Smith</u>		(Month) (Day) (Year)	<u>12 - 18 - 54</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 23, 1888</u>		9. AGE (in years last birthday) <u>66</u>	IF UNDER 1 YEAR Months <u>6</u>	IF UNDER 24 HRS. Days <u>6</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (State or foreign country) <u>Rock Port, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>		
13a. FATHER'S NAME <u>Edward McFadden</u>		13b. MOTHER'S MAIDEN NAME <u>Mary McMullen</u>		14. NAME OF HUSBAND OR WIFE <u>Robert Smith</u>			
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>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Zelma Bauer</u>		ADDRESS <u>New Canton Ill</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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial (acute)</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Fracture of left femur bone</u>					<u>12 days</u>	
	DUE TO (c) <u>Paralysis agitans</u>					<u>4 years</u>	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes Mellitus</u>					<u>3 years</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION						
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>Aug 8, 1951</u> , to <u>Dec 18, 1954</u> , that I last saw the deceased alive on <u>Dec 17, 1954</u> , and that death occurred at <u>4:50 P.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>E. L. Gotten, BS, DO</u>				23b. ADDRESS <u>412 Centre St. Hannibal, Mo</u>		23c. DATE SIGNED <u>12/20/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>12-21-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Taylor Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Rock Port, Ill.</u>			
DATE REC'D BY LOCAL REG. <u>12-20-54</u>	REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke by W. E. Fisher</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Clark</u>			ADDRESS <u>Hannibal, Mo.</u>

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED **DEC 22 1954**  
MARION CO. HEALTH DEPT.  
DATE FILED **DEC 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 .....  
Student Embalmer

Signed 

Licensed Embalmer No. 4217

P. O. Address Hannibal, 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.