

Dr. Frank
FILED MAY 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16020
Registrar's No. 133

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Ralls	
b. CITY OR TOWN Hannibal		c. CITY OR TOWN RFD #1, Hannibal	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Elizabeth Hospital		d. STREET ADDRESS (If rural, give location) RFD #1	

3. NAME OF DECEASED (Type or Print) a. (First) Melchior b. (Middle) Hirner c. (Last) Hirner	4. DATE OF DEATH (Month) (Day) (Year) 5-3-1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1-6-1875	9. AGE (In years last birthday) 80	10 UNDER 1 YEAR Months Days	10 OVER 1 YEAR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Wietenberg, Germany	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Anthony Hirner	13b. MOTHER'S MAIDEN NAME Mary Hildebrandt	14. NAME OF HUSBAND OR WIFE Angelique Hirner
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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. _____	17. INFORMANT'S SIGNATURE OR NAME Mrs. Angelique Hirner, RFD #1,	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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION Hannibal, Mo.		INTERVAL BETWEEN ONSET AND DEATH ?
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) adverse atherosclerotic heart disease		
	II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 4200	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)
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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? 4200
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22. I hereby certify that I attended the deceased from **Jan 1955**, to **5-3-55**, 19**55**, that I last saw the deceased alive on **5-3-55**, 19**55**, and that death occurred at **10:15 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) MD	23b. ADDRESS Hannibal Mo	23c. DATE SIGNED 5-3-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5/6/1955	24c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	24d. LOCATION (City, town, or county) (State) Hannibal, Mo.
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DATE REC'D BY LOCAL REG. May 9-1955	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Hannibal Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAY 16 1955

RECEIVED

MARION CO. HEALTH DEPT.

DATE FILED MAY 16 1955

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

working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Michael J. O'Rourke*

Licensed Embalmer No. *3249*

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.