

FILED JUL 13 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **19446**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3043** Registrar's No. **184**

1. PLACE OF DEATH a. COUNTY <b>Marion</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Marion</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Hannibal</b>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>Hannibal</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Levering Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>R.F.D. #2</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Martin</b> b. (Middle) <b>Erhardt</b> c. (Last) <b>Raithe</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>June 17, 1955</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 9, 1897</b>
9. AGE (In years last birthday) <b>57</b>		10. MONTHS <b>11</b>	11. DAYS <b>8</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hannibal Courier Post</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Verona, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13a. FATHER'S NAME <b>John Raithe</b>	
13b. MOTHER'S MAIDEN NAME <b>Emilie Fellwock</b>		14. NAME OF HUSBAND OR WIFE <b>Hattie Reynolds Raithe</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes World War I</b>		16. SOCIAL SECURITY NO. <b>490-07-9522</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Hattie Reynolds Raithe</b> ADDRESS <b>Hannibal, Mo.</b>
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) <b>Coronary Occlusion (D.O.A.)</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Coronary occlusion</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>4201</b>	
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)		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 <b>6/17/55</b> , 19 <b>55</b> , to <b>6/17/55</b> , 19 <b>55</b> , that I last saw the deceased alive on _____, 19____, and that death occurred at <b>2:30 A. m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Robert J. Lanning</b> (Degree or title) <b>MD</b>		23b. ADDRESS <b>Hannibal, Mo</b>	
23c. DATE SIGNED <b>6/17/55</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
24b. DATE <b>June 20, 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>Hannibal, Missouri</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Dr. E.M. Lucke</b> ADDRESS <b>Hannibal, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>6-28-55</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Dr. E.M. Lucke</b> ADDRESS <b>Hannibal, Missouri</b>	

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

RECEIVED JUL 12 1955  
MARION CO. HEALTH DEPT.  
DATE FILED JUL 12 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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *H. C. Crawford Smith*.....

Licensed Embalmer No. *381*

P. O. Address *H. C. Crawford Smith*

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.