

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21416**

FILED AUG 1 - 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **52** PRIMARY REG. DIST. NO. **3007** Registrar's No. **142**

1. PLACE OF DEATH a. COUNTY <b>Cape Girardeau</b>			2. USUAL RESIDENCE (Where deceased lived at institution, residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cape Girardeau</b>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Jackson</b>		c. LENGTH OF STAY (in this place) <b>10 yrs</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Jackson</b>		01010
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>214 Daisy St</b>			d. STREET ADDRESS (If rural, give location) <b>214 Daisy St</b>		

3. NAME OF DECEASED (Type or Print) a. (First) <b>ANNIE</b> b. (Middle) <b>AMERICA</b> c. (Last) <b>HARTLE</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>July 22, 1953</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb 3, 1868</b>		9. AGE (in years last birthday) <b>87</b>	if UNDER 1 YEAR Months	if UNDER 24 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Daisy Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
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13a. FATHER'S NAME <b>Marion Drum</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Finkle</b>		14. NAME OF HUSBAND OR WIFE <b>Peter F. Hartle</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	(If yes, give year or dates of service) <b>none</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Peter F. Hartle</b> ADDRESS <b>Jackson Mo.</b>		
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>arteriosclerotic atherosclerosis</b>	DUPLICATE				1 mo
ANTECEDENT CAUSES	DUPLICATE				Doubt Heart
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUPLICATE				334X
DUE TO (b) <b>arteriosclerosis</b>	DUPLICATE				
DUE TO (c)	DUPLICATE				
II. OTHER SIGNIFICANT CONDITIONS	DUPLICATE				None
Conditions contributing to the death but not related to the disease or condition causing death.	DUPLICATE				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
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22. I hereby certify that I attended the deceased from **June 1953** to **July 22, 1953**, that I last saw the deceased alive on **July 19, 1953**, and that death occurred at **7 P. M.** from the causes and on the date stated above.

23a. SIGNATURE <b>D. L. Dickman M.D.</b> (Degree or title)		23b. ADDRESS <b>Ballwin Mo.</b>		23c. DATE SIGNED <b>7-23-53</b>	
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24a. BURIAL / CREMATION (Specify) <b>Burial</b>	24b. DATE <b>July 24, 1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Old Salem</b>	24d. LOCATION (City, town, or county) (State) <b>near Melleysville Mo.</b>		
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DATE REC'D BY LOCAL REG. <b>7/26/53</b>	REGISTRAR'S SIGNATURE <b>R. A. Seabach</b> 518		25. FUNERAL DIRECTOR'S SIGNATURE <b>J. Miller</b> ADDRESS <b>Jackson Mo.</b>		
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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

*Lynnan Steele*  
Licensed Embalmer No. *2476*

P. O. Address *Quakertown*

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.