

FILED AUG 24 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26992

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 240

1. PLACE OF DEATH a. COUNTY Marion County		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Shelby	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Shelbina, Mo. 1020	
c. LENGTH OF STAY (In this place) 1 Day		d. STREET ADDRESS (If rural, give location) X	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Elizabeth Hoppt.			

3. NAME OF DECEASED (Type or Print)	a. (First) MINNIE	b. (Middle) ALICE	c. (Last) MARTIN	4. DATE OF DEATH (Month) (Day) (Year) 8-10-1955
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH 6-15-1879	9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) 76 1 25
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House hold	10b. KIND OF BUSINESS OR INDUSTRY Same	11. BIRTHPLACE (State or foreign country) Mason City, Nebr. /	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Franklin Boden	13b. MOTHER'S MAIDEN NAME Harriet Philips	14. NAME OF HUSBAND OR WIFE Deceased
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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 X	16. SOCIAL SECURITY NO. X	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Lotus Moon, She;bina, Mo.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis of Anterior myocardial infarction		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4200	
19a. DATE 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) (m.)	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **3:20 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Deputy or Title) <i>[Signature]</i>	23b. ADDRESS 1004 6th St Hannibal	23c. DATE SIGNED
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-12-1955	24c. NAME OF CEMETERY OR CREMATORY I.O.O.F.
24d. LOCATION (City, town, or county) (State) Shelbina, Mo.		

DATE REC'D BY LOCAL REG. 8-16-55	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bartlelew & Hawkins, Shelbina Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED AUG 23 1955
MARION CO. HEALTH DEPT.
DATE FILED AUG 23 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
Student Embalmer

Signed _____

W. H. Harris

Licensed Embalmer No. 3498

P. O. Address St Albans 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.