

STANDARD CERTIFICATE OF DEATH

State File No. **34034**

FILED NOV 2 1955

BIRTH NO. _____ REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3043** Registrar's No. **323**

1. PLACE OF DEATH a. COUNTY MARION		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY MARION	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN HANNIBAL		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Palmyra	
c. LENGTH OF STAY (in this place) 55 yrs		d. STREET ADDRESS (If rural, give location) RURAL ROUTE #2	
d. FULL NAME OF HOSPITAL OR INSTITUTION LEYERING			

3. NAME OF DECEASED (Type or Print) a. (First) LAURA b. (Middle) CAROLINE c. (Last) BODE			4. DATE OF DEATH (Month) (Day) (Year) 10-24-1955				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 6-16-1900	9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months 4 Days 8	IF OVER 1 YEAR Years - Months - Days -	IF OVER 60 YEARS Hours - Mins. -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY U.S.	
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13a. FATHER'S NAME JOHN SCHLOCKEBIER		13b. MOTHER'S MAIDEN NAME EMMA SMITH		14. NAME OF HUSBAND OR WIFE Godfrey Bode	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME Godfrey Bode Palmyra RR#2		ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) inoperable bronchogenic carcinoma		left lung				4 MOS.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 162X					
		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.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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)		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 **9-28-55**, 19____, to **10-24-55**, 19____, that I last saw the deceased alive on **10-24-55**, 19____, and that death occurred at **11:45 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Richard M. Strong M.D.		23b. ADDRESS 115 N. 5th St. Hannibal, Mo.		23c. DATE SIGNED 10-28-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 10/27/55		24c. NAME OF CEMETERY OR CREMATORY KATHERAN		24d. LOCATION (City, town, or county) (State) WEST ELY MO	
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DATE REC'D BY LOCAL REG. 10-29-55		REGISTRAR'S SIGNATURE Dr. Em. Lucke		25. FUNERAL DIRECTOR'S SIGNATURE Harold James		ADDRESS Monroe City	
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(Licensed Embalmer's Statement on Reverse Side)

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

