

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27632

STATE FILE NUMBER

FILED SEP 6 1956

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 304

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN <b>Hannibal</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Hannibal</b> <i>0644</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Levering Hospital</b> Length of stay in 1b		d. STREET ADDRESS <b>901 Pleasant Street</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>Marguerite Josephine Cole</b>		4. DATE OF DEATH <b>Month Day Year</b> <b>August 30, 1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 23, 1906</b>
9. AGE (In years last birthday) <b>50</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>4</b> Days <b>7</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C. Lee Downey Co.</b>	
11. BIRTHPLACE (City and state or country) <b>St. Louis Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Roger B. Buchanan</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Stipating</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>493 28 6297</b>	
17. INFORMANT <b>F. Owen Cole</b>		Address <b>Hannibal Missouri</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of pancreatic duct C</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>melanosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>157X</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY: Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>June 18, 1956</b> to <b>Aug 30, 1956</b> and last saw <sup>her</sup> <del>him</del> alive on <b>Aug 30, 1956</b> . Death occurred at <b>9:16 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Robert Lanning M.D.</b>		22b. ADDRESS <b>Hannibal, Mo</b>	
22c. DATE SIGNED <b>8/30/56</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/1/1956</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Philadelphia</b>		23d. LOCATION (City, town, or county) (State) <b>Philadelphia Missouri</b>	
24. FUNERAL DIRECTOR <b>H. C. ...</b> ADDRESS <b>Hannibal Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>8-31-56</b>	
26. REGISTRAR'S SIGNATURE <b>Dr. E. M. Lucke</b>			

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED SEP 4 1956  
MARION CO. HEALTH DEPT.  
DATE FILED SEP 4 1956

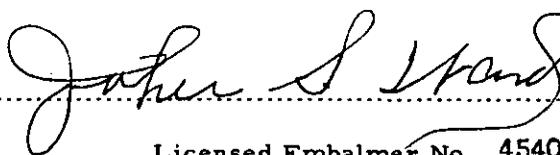
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MAY 3  
1961

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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.....  


Licensed Embalmer No...4540

P. O. Address. Hannibal, Mis

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.