

STANDARD CERTIFICATE OF DEATH

31393

FILED SEP 28 1956

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 327

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 causally 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 <u>MARION</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MONROE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HANNIBAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>MONROE CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <u>6690</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST ELIZABETH HOSPT</u> Length of stay in 1b <u>6 HOURS</u>		d. STREET ADDRESS (If outside, give location) <u>404 WINTER ST</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NORMA JEAN HAGAR</u>			4. DATE OF DEATH Month Day Year <u>SEPT 20 1956</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 30, 1930</u>
9. AGE (In years last birthday) <u>26</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Shoe FACTORY</u>	11. BIRTHPLACE (City and state or country) <u>SHELBYNA, MO</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOE BUILDER</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RUSSELL L. PETERS</u>		14. MOTHER'S MAIDEN NAME <u>NELLIE MCKINNEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>497-30-8425</u>	
17. INFORMANT <u>Russell L Peters</u> Address <u>Monroe City Mo</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Concussion, due to</u> DUE TO (c) <u>accident.</u> 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 <u>4 hrs.</u>
20a. ACCIDENT <input checked="" 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 <u>840 a. m. 9-19-56</u>		<u>Automobile accident. 119</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>45 Spruce St. 36. Belle Co Mo</u>	
20f. CITY/TOWN, OR LOCATION <u>Hannibal, Marion, Mo.</u>		COUNTY STATE	
21. I attended the deceased from <u>9/19/56</u> to <u>9/19/56</u> and last saw her alive on <u>9/19/56</u> Death occurred at <u>2:15 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. Schwattschinski M.D.</u>		22b. ADDRESS <u>Hannibal Mo</u>	
22c. DATE SIGNED <u>9/24/56</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>9-22-56</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St JUDES CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONROE CITY, MO</u>	
24. FUNERAL DIRECTOR <u>Wilson & Sons</u> ADDRESS <u>Monroe City Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9-24-56</u>	
26. REGISTRAR'S SIGNATURE <u>Dr. E.M. Lucke by W.P. Fisher</u>			

RECEIVED SEP 26 1956
MARION CO. HEALTH DEPT.
DATE FILED SEP 26 1956

FOR [unclear]

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.....
Leslie L. Ashby

Licensed Embalmer No. 2014

P. O. Address *Monroe City*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.