

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

THE DIVISION OF REALTY OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34779

STATE FILE NUMBER

FILED NOV 5 - 1956

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 370

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|--|--|---|--|
| 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, give TOWNSHIP only) OR TOWN Hannibal | | c. CITY OR TOWN Hannibal <i>0648</i> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Levering Hospital | | d. STREET ADDRESS (If outside, give location) 908 Park Avenue | |

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|---|--|--|--|--|---|
| 3. NAME OF DECEASED (Type or print) George B. Helwig | | | 4. DATE OF DEATH October 24, 1956 | | |
| 5. SEX Male | | | 6. COLOR OR RACE White | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH July 14, 1860 | | |
| 9. AGE (In years last birthday) 96 | | | IF UNDER 1 YEAR 3 Months 10 Days | | IF UNDER 24 HRS. 10 Hours 15 Min. |

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|--|--|---|--|--|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY R. R. Engineer | | 11. BIRTHPLACE (City and state or country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? USA | |
|--|--|---|--|--|--|---|--|

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|---|--|---|--|
| 13. FATHER'S NAME David B. Helwig | | 14. MOTHER'S MAIDEN NAME Sarah Craig | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Edward M Helwig | | Address Hannibal Missouri | |

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|---|--|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Submaxillary gland with Metastasis | | INTERVAL BETWEEN ONSET AND DEATH 2 months | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (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) 1421 | | | |

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|---|--|--|--|--|--|
| 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. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | | |
|--|--|--|---|--|--|---|--|--|

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|--|--|--|---|--|--|---|--|--|
| 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 9/24/56 to 10/24/56 and last saw her/him alive on 10/24/56 Death occurred at 1:40 P m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
|--|--|--|--|--|--|

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|---|--|--|--|----------------------------------|--|
| 22a. SIGNATURE Robert Lanning M.D. (Degree or title) | | 22b. ADDRESS B & L Building, Hannibal, Missouri | | 22c. DATE SIGNED 10/26/56 | |
|---|--|--|--|----------------------------------|--|

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|---|--|---------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 10/26/56 | | 23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery | | 23d. LOCATION (City, town, or county) (State) Hannibal Missouri | |
|---|--|---------------------------|--|--|--|--|--|

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|--|--|--|--|--|--|
| 24. FUNERAL DIRECTOR W. J. ... ADDRESS Hannibal Missouri | | 25. DATE RECD. BY LOCAL REG. 10-29-56 | | 26. REGISTRAR'S SIGNATURE Dr. E. M. Lucke | |
|--|--|--|--|--|--|

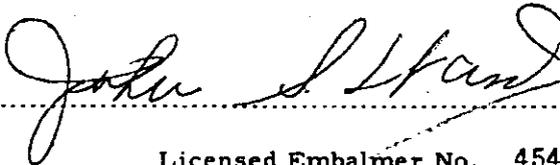
(Licensed Embalmer's Statement on Reverse Side)

RECEIVED NOV 2 1956
MARION CO, HEALTH DEPT,
DATE FILED NOV 2 1956

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....454

P. O. Address Hannibal, Mis

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