

Public Health Service
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 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
 9-0

Dr. Koller
 FILED NOV 5 - 1956

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

34785

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 379

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>MARION</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>HANNIBAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Elizabeth</u>			Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>1117 Woodrow</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>LOUISE</u> Last <u>LARGE</u>				4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>56</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-6-1942</u>		9. AGE (In years last birthday) <u>14</u>	IF UNDER 1 YEAR Months <u>14</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>HANNIBAL</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Roy Large</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Amos</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>—</u>	17. INFORMANT Address <u>Mrs. Gertrude Large 1117 Woodrow Hannibal, 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>Major Brain injury + Contusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral fracture skull -</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>Fracture middle third left femur</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <u>Auto accident - 8254</u>				
20c. TIME OF INJURY Hour <u>—</u> Month <u>10</u> Day <u>18</u> Year <u>56</u> a. m. <u>—</u> p. m. <u>—</u>		20d. PLACE OF INJURY (e. g., in or about home, farm, factory/street, office/bldg., etc.) <u>Street Hi 36 2 1/2 miles East Mt Olive Pike, Mo</u>					
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>Hannibal</u>	COUNTY <u>Mo</u>	STATE <u>Mo</u>				
21. I attended the deceased from <u>10-18-56</u> to <u>10-19-56</u> and last saw her alive on <u>10-19-56</u> Death occurred at <u>7:10 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>M. Koller</u> (Degree or title)				22b. ADDRESS <u>Hannibal Mo</u>		22c. DATE SIGNED <u>Oct 29/56</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-22-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVE CEMETERY</u>		23d. LOCATION (City, town, or county) <u>Hannibal, Mo</u>		(State)	
24. FUNERAL DIRECTOR <u>J. M. O'Donnell</u> ADDRESS <u>Hannibal Mo</u>			25. DATE RECD. BY LOCAL REG. <u>10/30/1956</u>		26. REGISTRAR'S SIGNATURE <u>D. E. M. Lucke, Capt. C. Fisher</u>		

(Licensed Embolmer'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 em-
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *W. M. O'Donnell*

Licensed Embalmer No. *388*

P. O. Address *Harrisburg*

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.