

FILED DEC 3 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38757

STATE FILE NUMBER

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 419

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	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Clark Rest Home		d. STREET ADDRESS 2000 Spruce	
3. NAME OF DECEASED (Type or print) MAMIE		4. DATE OF DEATH November 24, 1956	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH August 31, 1878	
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Monteville Clark		14. MOTHER'S MAIDEN NAME Emma Rosser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ellis McClenning, Chicago, Illinois		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Arteriosclerosis 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 48 hours 6 yr.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		331X	
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 _____ 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 11-22-56 to 11-24-56 and last saw her alive on 11-23-56 Death occurred at 9:45 P m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Glenn R. Miller D.O.	
22b. ADDRESS Hannibal Mo		22c. DATE SIGNED 11-26-56	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/27/1956	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet		23d. LOCATION (City, town, or county) (State) Hannibal Missouri	
24. FUNERAL DIRECTOR W. Crawford Smith		25. DATE RECD. BY LOCAL REG. 11/27/56	
26. REGISTRAR'S SIGNATURE W. E. Lucke By J. C. Fisher			

(Licensed Embalmer's Statement on Reverse Side)

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

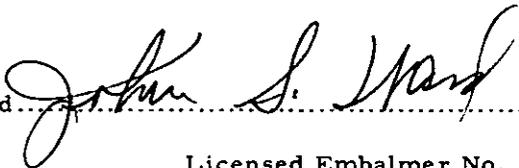
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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.... 15

P. O. Address Hannibal, Mi

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.