

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42168

STATE FILE NUMBER

FILED DEC 17 1956

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 438

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 type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Hannibal</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Levering Hospital</u>				Length of stay in 1b		d. STREET (If outside, give location) ADDRESS <u>2112 Spruce Street</u>		Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>OLLIE MAY MCDONALD</u>						4. DATE OF DEATH <u>December 4, 1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 21, 1884</u>		9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>?</u> Hours <u>?</u> Min. <u>?</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Madisonville Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Eaton Smith Painter</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Elizabeth Tribble</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> <u>None</u>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. J. R. Riley, Hannibal Missouri</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>Cerebral Vascular Hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>Bronchial Pneumonia</u>		DUE TO (c) <u>331 X</u>		2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 <u>?</u> Month <u>?</u> Day <u>?</u> Year <u>?</u> a. m. <u>?</u> p. m. <u>?</u>								
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 <u>11/23/1956</u> to <u>12/4/1956</u> and last saw her/him alive on <u>12/4/1956</u> Death occurred at <u>12:45 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Henry Manning D</u> (Degree or title)				22b. ADDRESS <u>B & L Building, Hannibal, Mo.</u>		22c. DATE SIGNED <u>12/6/1956</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/6/56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>			
24. FUNERAL DIRECTOR <u>Hessop</u> <u>Hannibal Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>12/11/1956</u>		26. REGISTRAR'S SIGNATURE <u>Wm Lucke Byt C Fisher</u>		

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300 1-56

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

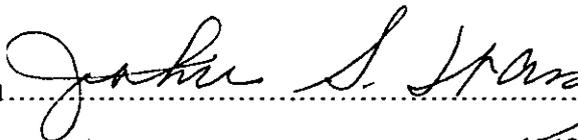
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

RECEIVED DEC 13 1956
MARION CO. HEALTH DEPT.,
DATE FILED DEC 13 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...4540

P. O. Address..Hannibal..Mo

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.