

health, Welfare public service
 300
 1-56
 All 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
 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.

Dr. Walterschied
 FILED FEB 25 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **5508**

Registration District No. <u>209</u>		Primary Registration District No. <u>3043</u>		Registrar's No. <u>56</u>	
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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Hannibal		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Levering Hospital		Length of stay in 1b	d. STREET ADDRESS 418 Center		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Arthur Fetter			First	Middle	Last
4. DATE OF DEATH 2-5-1957			Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/6/1891	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman	100. KIND OF BUSINESS OR INDUSTRY Bob's Lunch	11. BIRTHPLACE (City and state or country) Brookfield, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Fetter			14. MOTHER'S MAIDEN NAME Mary Grove		
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.	17. INFORMATION Address Mrs. G.E. Campbell, Illmo, Mo.		
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident					INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Small aneurysm cerebral vessels		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Lies					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.) 331x		
20c. TIME OF INJURY Hour a. m. p. m.					
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.)	20f. CITY, TOWN, OR LOCATION Hannibal Missouri		STATE
21. I attended the deceased from 2/4/57 to 2/5/57 and last saw her/him alive on 2/5/57 Death occurred at 12:45 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) J. W. Walterschied M.D.			22b. ADDRESS Hannibal Mo.		22c. DATE SIGNED 2/8/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/8/57	23c. NAME OF CEMETERY OR CREMATORY M. t. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Hannibal, Missouri	
24. FUNERAL DIRECTOR J. M. O'Donnell		ADDRESS Hannibal, Mo.	25. DATE RECD. BY LOCAL REG. 2/13/57	26. REGISTRAR'S SIGNATURE J. E. M. Lucke By B. Hunter	

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED FEB 19 1957
MARION CO. HEALTH DEPT.
DATE FILED FEB 19 1957

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 *J. M. A. Donnell*.....

Licensed Embalmer No..... 3

P. O. Address Hannibal,

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