

FILED FEB 25 1957

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 60

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> <u>0649</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>Levering</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>1908 Spruce</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Isaac</u> Middle <u>Dill</u> Last <u>Ledbetter</u>			4. DATE OF DEATH <u>2-8-57</u> Month <u>2</u> Day <u>8</u> Year <u>57</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/9/1878</u>
9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Crossing Watchman, C.B.&Q</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pike County, Ill.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Isaac Ledbetter</u>		14. MOTHER'S MAIDEN NAME <u>Elsie Hoots</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.	17. INFORMANT <u>Mrs. Ethel Ledbetter, 1908 Spruce</u> 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) <u>Cerebral vascular Accident rt.</u> 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)			INTERVAL BETWEEN ONSET AND DEATH <u>1st day</u>
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.) <u>331x</u>	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ 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.) <u>Hannibal, Mo.</u>	
		20f. CITY, TOWN, OR LOCATION <u>Hannibal, Mo.</u> COUNTY <u>Marion</u> STATE _____	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>5:15 P.M.</u> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>D. H. Walterscheid M.D.</u> (Degree or title)		22b. ADDRESS <u>Hannibal Mo</u>	
		22c. DATE SIGNED <u>2/3/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/11/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Pk</u>	23d. LOCATION (City, town, or county) (State) <u>Hannibal, Mo</u>
24. FUNERAL DIRECTOR <u>H M O'Donnell</u> ADDRESS <u>Hannibal, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-13-57</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke</u>

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300
4-56

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

39-0

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..... *W. M. O'Donnell*

Licensed Embalmer No. 388

P. O. Address Hannibal,

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.