

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9396

STATE FILE NUMBER

FILED APR 10 1957

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 121

Health, Welfare Public Service

300 1-56

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Pike</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>New Canton</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 lb	d. STREET ADDRESS (If outside, give location) <u>812 8</u>			Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mrs Elizabeth</u> Middle <u>Kurtz</u> Last <u>Kurtz</u>				4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Female</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>JAN 15 1914</u>		9. AGE (In years last birthday) <u>82</u> IF UNDER 1 YEAR: Months <u>8</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS. Months <u>0</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>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Timothy Soldwedel</u>				14. MOTHER'S M. IDEN NAME <u>Anne Soldwedel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mrs Lydia Winner New Canton</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>Terminal; Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Fracture right hip</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>34 days</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.)				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____							
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 <u>812 8</u>		COUNTY _____ STATE _____	
21. I attended the deceased from <u>Feb. 25, 1957</u> to <u>April 1, 1957</u> and last saw <u>her</u> alive on <u>4-1-1957</u> Death occurred at <u>6:30 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>M. Canella M.D.</u> (Degree or title)				22b. ADDRESS <u>707 Bdwy, Hannibal, Mo.</u>		22c. DATE SIGNED <u>4-1-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Apr 3 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shearer</u>		23d. LOCATION (City, town, or county) <u>New Canton</u>		(State) <u>Ill</u>	
24. FUNERAL DIRECTOR <u>A. M. O'Donnell</u>		ADDRESS <u>Hannibal Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4-2-1957</u>		26. REGISTRAR'S SIGNATURE <u>H. C. Fisher</u>	

RECEIVED APR 8 1957
MARION CO. HEALTH DEPT.
DATE FILED APR 8 1957

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..... *J. M. O'Donnell*

Licensed Embalmer No. *3885*

P. O. Address *Hannibal*

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