

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAY 6 - 1957

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 157

Health,  
& Welfare  
Public  
Service

S. 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. Securing the medical certification in the specific manner required by 193.140-140.145.

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>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>0644</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 Hospital</u> Length of stay in <u>1b</u>		d. STREET ADDRESS (If outside, give location) <u>1900 Hope</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN C FREW</u> First Middle Last			4. DATE OF DEATH <u>April 24, 1957</u> Month Day Year
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 4, 1876</u>
9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>20</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Lineman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Atlas Portland Cement</u>	11. BIRTHPLACE (City and state or country) <u>Monmouth Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Robert M. Frew</u>	
14. MOTHER'S MAIDEN NAME <u>No Record</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No None</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>M. J. Johnston Hannibal Missouri</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 Thrombosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>332x</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Granular Nephritis - uremia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</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 <u>10:55 AM</u> Month, Day, Year a. m. p. m.		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <u>Hannibal Missouri</u> COUNTY STATE	
21. I attended the deceased from <u>2-22-57</u> to <u>4-24-57</u> and last saw her/him alive on <u>4-24-57</u> . Death occurred at <u>10:55 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Physician or title) <u>[Signature]</u>		22b. ADDRESS <u>Hannibal Mo</u>	
22c. DATE SIGNED <u>4/26/57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>April 27, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Hannibal Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>Hannibal Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>4/30/57</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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RECEIVED MAY 3 1957  
MARION CO. HEALTH DEPT.  
DATE FILED MAY 3 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 *John S. Spence*

Licensed Embalmer No. .... 4540

P. O. Address ..Hannibal, Miss

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.