

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13949
STATE FILE NUMBER

FILED APR 22 1957

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 130-129

Health & Welfare
Public Service

S. 300
1-56

securing the medical certificate in the same manner as in the case of a death due to natural causes. 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

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> 0644 0
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Elizabeth Hospital</u>		Length of stay in lb <u>3/25/57</u>	d. STREET-ADDRESS (If outside, give location) <u>2611 Marsh Avenue</u>
3. NAME OF DECEASED (Type or print) First <u>GLADYS</u> Middle <u>MARIE</u> Last <u>LEWIS</u>			4. DATE OF DEATH Month <u>March</u> Day <u>29</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>June 6, 1897</u>
9. AGE (In years last birthday) <u>59</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>23</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. 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>Hannibal Missouri</u>
13. FATHER'S NAME <u>Charles E. Dreyer</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Lavinia Ainge</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>490 07 4844</u>	17. INFORMANT <u>George H. Lewis, 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>myocardial failure & kidney shutdown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arterio sclerotic cardio vascular disease</u>			<u>2 yrs</u>
DUE TO (c) <u>hypertension</u>			<u>12 yrs</u>
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 _____ 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.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>3/25/57</u> to <u>3/29/57</u> and last saw ^{her} him <u>alive on 3/29/57</u> Death occurred at <u>11:50 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Francis S. Seltzman M.D.</u> (Degree or title)		22b. ADDRESS <u>HANNIBAL MO</u>	22c. DATE SIGNED <u>Apr 1-8-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>April 1, 1957</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>W. Crawford Smith</u>	ADDRESS <u>Hannibal Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>4-8-57</u>	26. REGISTRAR'S SIGNATURE <u>Dr. Em. Lucke By W. C. Fisher</u>

RECEIVED APR 18 1957
MARION CO. HEALTH DEPT.
DATE FILED APR 18 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 *H. Crawford Smith*

Licensed Embalmer No. 3814

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.