

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31327**

FILED SEP 26 1957

BIRTH NO. _____		REG. DIST. NO. <u>102</u>		PRIMARY REG. DIST. NO. <u>5416</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution) a. STATE <u>Mo</u> b. COUNTY <u>Dunklin</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Cardwell</u> )		c. LENGTH OF STAY (In this place) <u>13 MONTHS</u>		c. CITY OR TOWN <u>Cardwell</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				e. STREET ADDRESS (If rural, give location) <u>Rt #1 0350</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ALONZO</u>		b. (Middle) _____		c. (Last) <u>HANKS.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>9-18-1957</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>6/16/1886</u>	
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Months <u>3</u>		IF UNDER 24 HRS. Days <u>2</u>		IF UNDER 1 MIN. Hours <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>William H. Hanks</u>		13b. MOTHER'S MAIDEN NAME <u>Mrs Kacie White</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs Bessie Hanks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>L W Hanks</u>		ADDRESS <u>Cardwell Mo</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Vascular Accident</u>				INTERVAL BETWEEN ONSET AND DEATH _____	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis.</u>					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) <u>331X</u> (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Nov 26</u> , 19 <u>56</u> , to <u>Sept 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>18 Sept</u> , 19 <u>57</u> , and that death occurred at <u>10:15 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Mr. Swafford M.D.</u> (Degree or title)				23b. ADDRESS <u>Cardwell Mo</u>		23c. DATE SIGNED <u>20 Sept 57</u>	
24a. BURIAL, CREMATION, DISPOSITION _____		24b. DATE <u>9/21/1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Baker Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Scottsville Mo</u>	
DATE REC'D BY LOCAL REG. <u>9-20-57</u>		REGISTRAR'S SIGNATURE <u>Edna Hallmael</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Emerson T San Janshero Ark</u> ADDRESS _____			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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RECEIVED DUNKLIN COUNTY HEALTH  
DEPARTMENT 9222  
(Serial Number) 957

**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 *[Signature]*.....  
Licensed Embalmer No. 895  
P. O. Address *[Address]*

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.