

Health,
Welfare
Public
Service

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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32663

STATE FILE NUMBER

FILED SEP 25 1957

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 362

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) <u>Hannibal</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Becky Thatcher Nursing Home</u>				Length of stay in lb		d. STREET ADDRESS <u>2100 Hope</u>	
3. NAME OF DECEASED (Type or print) First <u>MABEL</u> Middle <u>ELIZABETH</u> Last <u>KANE</u>				4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 3, 1878</u>		9. AGE (In years last birthday) <u>78</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Medical Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Ocean Wave, Ralls County Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Ernest U Kane</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Morris</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. <u>None</u>		17. INFORMANT <u>Mrs. Harry Sanders, 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>CVA acute</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>myocardial insufficiency progressive</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4222</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs</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 _____ 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 <u>Hannibal, Mo</u>		COUNTY STATE	
21. I attended the deceased from <u>1942</u> , to <u>9/14/57</u> and last saw her <u>alive</u> on <u>9/14/57</u> Death occurred at <u>12:50 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>W. E. Dultzman M.D. FACS</u>				22b. ADDRESS <u>115 N. 5th St., Hannibal, Mo</u>		22c. DATE SIGNED <u>9/17/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/16/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hydesburg</u>		23d. LOCATION (City, town, or county) (State) <u>Ralls County Missouri</u>		
24. FUNERAL DIRECTOR <u>W. E. Dultzman</u> ADDRESS <u>Hannibal Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>9-20-1957</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Luck</u>		

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED SEP 24 1957
MARION CO. HEALTH DEPT
DATE FILED SEP 24 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 *W. Crawford Smith*
.....

Licensed Embalmer No.

P. O. Address.... Hannibal, Mo.

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.