

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41119

FILED NOV 22 1957

STATE FILE NUMBER

Registration District No. 709 Primary Registration District No. 3043 Registrar's No. 452

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>Rails</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HANNIBAL</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>HANNIBAL</u> 0879 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Elizabeths Hosp.</u>		Length of stay in 1b <u>2 1/2 hrs.</u>	d. STREET ADDRESS <u>Rte 1</u> (If outside, give location) Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>Georgia</u> Last <u>Donel</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>15</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</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>June 17, 1885</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
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>Saveerton, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Peak</u>			14. MOTHER'S MAIDEN NAME <u>Alice Reynolds</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.	17. INFORMANT <u>Mrs. Louis Kincaid, Chambersburg, Ill.</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>Cerebrae Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive Cardio-Vascular Disease</u>	<u>Several years</u>
	DUE TO (c) <u>Arteriosclerotic Heart Disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Lymphedema</u>		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.) <u>—</u>	
20c. TIME OF "INJURY" Hour _____ Month _____ Day _____ a. m. _____ p. m. _____		
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT <input type="checkbox"/> WORK AT WORK	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. CITY, TOWN, OR LOCATION <u>—</u> COUNTY _____ STATE _____

21. I attended the deceased from <u>Nov 24, 1956</u> to <u>Nov 15, 1957</u> and last saw her alive on <u>11-15-57</u> Death occurred at <u>1:25 A</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Cornelius C. Welch, M.D.</u>	22b. ADDRESS <u>Hannibal, Mo</u>	22c. DATE SIGNED <u>11-18-57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>November 18, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hydesburg, Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Hydesburg, Missouri</u>
24. FUNERAL DIRECTOR <u>George E. Roberts</u>	ADDRESS <u>Hannibal, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-19-57</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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MARION CO. HEALTH DEPT.,  
DATE FILED NOV 19 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 *Geo E. Roberts*.....

Licensed Embalmer No. *2115*

P. O. Address *Hamm*.....

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.