

Dr. Lanning
FILED DEC 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41151
STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 455

300
-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Hannibal</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Elizabeth</u>			Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>814 Sycamore</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Schnelle</u> Last <u>Schnelle</u>				4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1957</u>						
5. SEX <u>Male</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>10/31/1875</u>		9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer (Retired)</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Quincy, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Jacob Schnelle</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Huegbe</u>			14. NAME OF HUSBAND OR WIFE <u>Anna Schnelle</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 Address <u>Mrs. Anna Schnelle, 814 Sycamore</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>Arteriosclerotic heart disease</u>						Hannibal, Mo.		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____		DUE TO (c) _____		4200				
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 checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m.			20d. INJURY OCCURRED WHILE AT <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>11/9/57</u> to <u>11/14/57</u> and last saw her/him alive on <u>11/14/57</u> Death occurred at <u>1:20 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <u>Robert Lanning - MD -</u>					22b. ADDRESS <u>115 N. 5th St. Hannibal, Mo.</u>			22c. DATE SIGNED <u>11/19/57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11/16/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>			23d. LOCATION (City, town, or county) <u>Hannibal, Mo.</u>		(State)		
24. FUNERAL DIRECTOR ADDRESS <u>H.M. O'Donnell, Hannibal, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>11/20/57</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E.M. Lucke By H.C. Fisher</u>				

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RECEIVED NOV 29 1957
MARION CO. HEALTH DEPT.
DATE FILED NOV 29 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 *N. M. O'Donnell*

Licensed Embalmer No. 3889

P. O. Address Hannibal, Mo.

**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.**