

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45075
STATE FILE NUMBER

FILED DEC 30 1957

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 487

V. S. 300
Rev. 1-57

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) HOSPITAL OR INSTITUTION <u>Levering Hospital</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>7420 West Ely Road</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>EDWIN</u> Last <u>CHEEK</u>			4. DATE OF DEATH Month <u>December</u> Day <u>11</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>September 14, 1889</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>27</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner & Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hannibal Crate Co.</u>	11. BIRTHPLACE (City and state or country) <u>Hannibal Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13a. FATHER'S NAME <u>George William Cheek</u>		13b. MOTHER'S MAIDEN NAME <u>Belle Brown</u>		14. NAME OF HUSBAND OR WIFE <u>Lyda Lindsey Cheek</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 Address <u>Mrs. Arthur E. Cheek 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 Infarction</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) _____ 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>4201</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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>29 Nov 1957</u> to <u>11 Dec 1957</u> and last saw ^{her} him alive on <u>10 Dec 1957</u> Death occurred at <u>5:25 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Wyneth Hamilton M.D.</u> (Degree or title)			22b. ADDRESS <u>Hannibal Mo.</u>		22c. DATE SIGNED <u>12/13/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/17/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>
24. FUNERAL DIRECTOR <u>H. C. ...</u> ADDRESS <u>Hannibal Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>12-16-57</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke</u>	

Securing the medical certificate in this specific manner required by 191.140 MoRS 1949.
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

RECEIVED DEC 27 1957

MARION CO. HEALTH DEPT.

DATE FILED DEC 27 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. C. Crawford*

Licensed Embalmer No. 5814 ~~1510~~

P. O. Address Hannibal, Missouri

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.