

Health,  
& Welfare  
S. Public  
th Service

Dr. Walterscheid

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

45097  
STATE FILE NUMBER

FILED DEC 30 1957

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 489

5. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Marion</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Marion</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <b>Hannibal</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Hannibal</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Elizabeth</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>206 N. 4th St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>L.</b> Last <b>Todd</b>			4. DATE OF DEATH <b>12/4/1957</b> Month <b>12</b> Day <b>4</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/6/1904</b>		9. AGE (In years last birthday) <b>53</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rug Cleaner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>	11. BIRTHPLACE (City and state or country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>William Todd</b>		13b. MOTHER'S MAIDEN NAME <b>Susan Lamb</b>		14. NAME OF HUSBAND OR WIFE <b>-</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mr. Thomas W. Todd, 406 W. Market</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
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) <b>None</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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 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 COUNTY STATE <b>Hannibal Marion Missouri</b>	
21. I attended the deceased from <b>12/4/57</b> to <b>12/4/57</b> and last saw her/him alive on <b>12/4/57</b> Death occurred at <b>10:50 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>[Signature]</i>			22b. ADDRESS <b>508 Broadway, Hannibal, Mo.</b>		22c. DATE SIGNED <b>12/10/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/6/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hannibal, Missouri</b>
24. FUNERAL DIRECTOR <b>H.M.O'Donnell, Hannibal, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-17-57</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

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 *Wm 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.