

Health,
& Welfare
S. Public
th Service

S. 300
v. 1-56

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED DEC 20 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45099
STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 304.3 Registrar's No. 485

| | | | | | |
|--|-------------------------------|---|---|---|---|
| 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 checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Levering Hospital</u> | | Length of stay in lb | | d. STREET ADDRESS <u>318 North Section</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>DORA</u> Middle <u>M.</u> Last <u>WILHELM</u> | | | 4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1957</u> | | |
| 5. SEX <u>Female</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>April 19, 1884</u> | 9. AGE (In years last birthday) <u>73</u> | IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Levering Hospital</u> | | 11. BIRTHPLACE (City and state or country) <u>Macon Missouri</u> | |
| 13. FATHER'S NAME <u>Jefferson Gray</u> | | | 14. MOTHER'S MAIDEN NAME <u>Wary E. Hassett</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u> | | 16. SOCIAL SECURITY NO. <u>498 76 6380</u> | | 17. INFORMANT <u>Leonard Wilhelm 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>Carcinoma of colon with metastasis</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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) | | | | | 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. _____ | | | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | | |
| 21. I attended the deceased from <u>11-30-57</u> , to _____ and last saw her/him alive on <u>12-8-57</u> Death occurred at <u>4:25 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | | 22b. ADDRESS <u>Hannibal Mo</u> | | 22c. DATE SIGNED <u>11 Dec 57</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>December 10, 1957</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u> | | 23d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u> |
| 24. FUNERAL DIRECTOR <u>[Signature]</u> | | 25. DATE RECD. BY LOCAL REG. <u>12-12-57</u> | | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

(Licensed Embalmer's Statement on Reverse Side)

89-0

RECEIVED DEC 17 1957
MARION CO. HEALTH DEPT.,
DATE FILED DEC 17 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 *John S. [Signature]*.....
Licensed Embalmer No.

P. O. Address Hannibal, Mis.

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.