

Dr. Hahn  
FILED FEB 24 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-005121  
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 163

300 0  
-57

1. PLACE OF DEATH a. COUNTY <b>Breene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Howell</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Pomona</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. John's Hosp.</b>		Length of stay in lb Wks	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>L.</b> Last <b>HANNER</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>16</b> Year <b>1958</b>	
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 20 1890</b>	9. AGE (In years of birthday) <b>67</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>	11. BIRTHPLACE (City and state or country) <b>Bonita, New Mexico</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>James C. Haggard</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah F. Allison</b>	14. NAME OF HUSBAND OR WIFE (Dec.)
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, No (unknown)) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Yes</b>	17. INFORMANT <b>Jane Martin</b> Address, Mo. <b>Pomona</b>
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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>Chronic myelocytic leukemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yr.</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)		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <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.) <b>2041</b>
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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
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21. I attended the deceased from <b>11-9-56 9:55 p.m.</b> to <b>2-16-58</b> and last saw her alive on <b>2-16-58</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Em Russell</b> (Degree or title)	22b. ADDRESS <b>M.D. 609 Cherry-Springfield, Mo.</b>	22c. DATE SIGNED <b>2-17-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>2/17/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn</b>	23d. LOCATION (City, town, or county) (State) <b>West Plains, Mo.</b>
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24. FUNERAL DIRECTOR <b>Robertson Funeral Home</b> ADDRESS <b>West Plains, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>2-18-58</b>	26. REGISTRAR'S SIGNATURE <b>Effie G. Melton</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc.: most are only temporary conditions and are not necessarily related to the disease in Part I

MAY 28 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate <sup>not</sup> ~~was~~ embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....

Signature of Student Embalmer

*Curt*

Signed *H. Z. McCann* .....

Licensed Embalmer No. *2222* .....

P. O. Address *Springfield, N.* .....

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.