

Health,  
Welfare  
Public  
Service

300  
9-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. 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. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-006289  
STATE FILE NUMBER

FILED MAR 11 1958

Registration District No. 171 Primary Registration District No. 4267 Registrar's No. 11

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Odessa</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Odessa</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>307 S. First</u>		Length of stay in 1b <u>1 month</u>		d. STREET ADDRESS (If outside, give location) <u>307 So. First</u>				
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>May</u> Last <u>Hannah</u>			4. DATE OF DEATH Month <u>Mar.</u> Day <u>4</u> Year <u>1958</u>					
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1872</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>agriculture</u>		11. BIRTHPLACE (City and state or country) <u>Odessa, Lafayette, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>James W. Hannah</u>				14. MOTHER'S MAIDEN NAME <u>Julia Garnhart</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Miss Mildred Hannah, Odessa, Mo.</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>Uremia and dehydration</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Senility Cerebral sclerosis</u> DUE TO (c) <u>Cardio renal vascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Had Pulm Pneumonia 4-5 weeks before death</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>		
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		
21. I attended the deceased from <u>Nov 1 - 57</u> , to <u>March 3 - 58</u> and last saw her/him alive on <u>March 3 - 58</u> . Death occurred at <u>1:25 A.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>M E Marten MD</u>				22b. ADDRESS <u>Odessa MO</u>		22c. DATE SIGNED <u>3-4-58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Mar. 6-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenton cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Odessa, Lafayette Mo.</u>		
24. FUNERAL DIRECTOR <u>Ralph O Jones</u>			ADDRESS <u>Odessa Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Mar. 6, 1958</u>		26. REGISTRAR'S SIGNATURE <u>Emma Davidson</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Ralph J. Jones*

Licensed Embalmer No. *46*

P. O. Address *Odesa*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.