

Dr. Sultzman

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014989
STATE FILE NUMBER

FILED MAY 2 1958

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 136

300

1-57

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

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 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>Clark's Rest Home</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>450 So. 7th St.,</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Minna</u> Middle <u>Sue</u> Last <u>Johnson</u>			4. DATE OF DEATH Month <u>3</u> Day <u>7</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 type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/25/1868</u>	9. AGE (In years last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Marion County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Robert Ward</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Powell</u>		14. NAME OF HUSBAND OR WIFE <u>T. K. Johnson</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.	17. INFORMANT Address <u>Mrs. Nell Tatman, 450 S. 7th</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>Cerebral vascular accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>myocardial insufficiency</u> DUE TO (c) <u>general debility of the aged</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>3 months</u> <u>1 year.</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 <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u>					
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
21. I attended the deceased from <u>2-19-58</u> to <u>3-7-58</u> and last saw <u>her</u> alive on <u>3-7-58</u> Death occurred at <u>2:30 P.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>Dr. Sultzman M.D.</u>			22b. ADDRESS <u>115 N. 5th St. Hannibal, Mo.</u>		22c. DATE SIGNED <u>3-14-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/10/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Philadelphia Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Philadelphia, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>H.M.O'Donnell, Hannibal, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>4/29/58</u>	26. REGISTRAR'S SIGNATURE <u>Wm Lucke By HCF Fisher</u>	

RECEIVED MAY 1 1958
MARION CO. HEALTH DEPT.
DATE FILED MAY 1 1958

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 *N. M. 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.