

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-022585

STATE FILE NUMBER

FILED JUN 30 1958

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 211

1. PLACE OF DEATH a. COUNTY <b>Marion</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Marion</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Hannibal</b> TOWN			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 Hosp</b>			Length of stay in 1b <b>9 wks</b>		8. STREET ADDRESS (If outside, give location) <b>835 Reservoir</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nora</b> Middle <b>Jane</b> Last <b>McKinney</b>				4. DATE OF DEATH Month <b>6</b> Day <b>23</b> Year <b>1958</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 4, 1892</b>		9. AGE (In years last birthday) <b>66</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Lamona, Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Willard Hawk</b>				14. MOTHER'S MAIDEN NAME <b>Ida Marr</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Geo A. McKinney - Hannibal, Mo.</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>Atheros Sclerotic Vasculal Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 year.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chl. Myocarditis</b>							<b>1 year.</b>	
DUE TO (c) <b>4221</b>								
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 <input type="checkbox"/> Month, Day, Year a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>								
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 <b>6/22/58</b> to <b>6/23/58</b> and last saw her alive on <b>6/23/58</b> Death occurred at <b>6:30 Am</b> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Rabert J. Lanning MD</b> (Deponent or title)				22b. ADDRESS <b>Hannibal Mo</b>			22c. DATE SIGNED <b>6-24-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6-24-58</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>Clark Funeral Home-Hannibal, Mo.</b>			ADDRESS <b>6-24-58</b>		25. DATE RECD. BY LOCAL REG. <b>6-24-58</b>		26. REGISTRAR'S SIGNATURE <b>Dr. E. M. Luckley, H. C. Fisher</b>	

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service

300 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 causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

**RECEIVED** JUN 26 1958  
**MARION CO. HEALTH DEPT.**  
**DATE FILED** JUN 26 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.....  


Licensed Embalmer No...421

P. O. Address Hannibal,...

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