

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5766 58-026281  
STATE FILE NUMBER

FILED JUL 16 1958 Registration District No. 209 Primary Registration District No. ~~2073~~ Registrar's No. 232

3  
v. 1-57  
5. 300

1. PLACE OF DEATH a. COUNTY <b>Marion</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Sedgewick</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal, Miller Turnap</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Valley Center</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Highway 76, 5 miles west Hannibal</b>		Length of stay in 1b <b>west Hannibal</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ANITA</b> Middle <b>MARIE</b> Last <b>SEIBEL</b>			4. DATE OF DEATH Month <b>July</b> Day <b>11</b> , Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 28, 1951</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>6</b> IF UNDER 1 YEAR Months <b>8</b> Days <b>22</b> IF UNDER 24 HRS. Hours <b>22</b> Min.
11. BIRTHPLACE (City and state or country) <b>Newton Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13a. FATHER'S NAME <b>Glenn Seibel</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Campbell</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>XX</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Clyde Campbell, Bowen Illinois</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>Fractured skull</b>			INTERVAL BETWEEN ONSET AND DEATH <b>immediate</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) <b>Fracture left thigh, left humerus.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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>Car in which she was riding swerved in front</b>		
20c. TIME OF INJURY Hour <b>7:30</b> a.m. <b>7</b> Month <b>7</b> Day <b>11</b> Year <b>58</b>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Tractor trailer truck</b> <b>Highway 36</b>		
20e. CITY, TOWN, OR LOCATION <b>Miller</b>	20f. COUNTY <b>Marion</b>	STATE <b>Mo</b>	
21. I attended the deceased from _____, to _____ and last saw her alive on _____ Death occurred at <b>7:30 A?</b> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Lenny H. Smith MD Corner 3</b>		22b. ADDRESS <b>Hannibal Mo</b>	22c. DATE SIGNED <b>7/12/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7/12/58</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <b>Wichita Kansas</b> <b>PERSONAL SERVICES</b>
24. FUNERAL DIRECTOR <b>W. Crawford Smith</b>		ADDRESS <b>Hannibal Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>7-12-58</b> 26. REGISTRAR'S SIGNATURE <b>W. E. Lucke by W. Fisher</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

**RECEIVED** JUL 15 1950  
**MARION CO. HEALTH DEPT.,**  
**DATE FILED** JUL 15 1950

**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 J. Ward* .....

Licensed Embalmer No. 4540 .....

P. O. Address ..... Hannibal, Missouri

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.