

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037120
STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 329

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 type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Elizabeth Hospital</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>664 RFD # 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>FRANK</u> Last <u>KUHN</u>			4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1958</u>
5. SEX <u>Male</u> <input type="checkbox"/> <u>Female</u> <input type="checkbox"/>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 3, 1890</u>
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months <u>24</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. 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>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Quincy Illinois / U.S.A</u>
13a. FATHER'S NAME <u>Edward Kuhn</u>		13b. MOTHER'S MAIDEN NAME <u>Anna</u>	14. NAME OF HUSBAND OR WIFE <u>Fannie Brooks Kuhn</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. <u>486 42 0319 A</u>	17. INFORMANT Address <u>Mrs. Robert Kuhn Hannibal Missouri</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>Hemorrhage</u> DUE TO (b) <u>Bleeding peptic ulcer</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Coronary Thrombosis 3 mo.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 da.</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.) <u>5400</u>	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ 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	
21. I attended the deceased from <u>June 1957</u> to <u>Oct 9, 1958</u> and last saw her/him alive on <u>10/9/58</u> Death occurred at <u>4:15 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. Lee M.D.</u>		22b. ADDRESS <u>Palmyra Mo.</u>	22c. DATE SIGNED <u>10/11/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/11/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>
24. FUNERAL DIRECTOR <u>Crawford Smith, Hannibal Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>10/14/58</u>	26. REGISTRAR'S SIGNATURE <u>N. Embelmer By J. C. Fisher</u>

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.

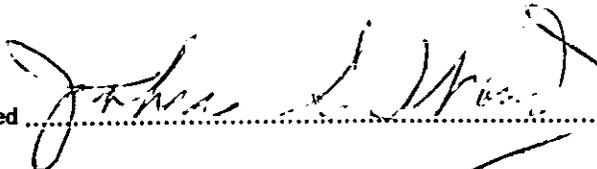
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

RECEIVED OCT 17 1958
MARION CO. HEALTH DEPT.
DATE FILED OCT 17 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. 1540

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.