

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037125  
STATE FILE NUMBER

FILED NOV 14 1958

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 360

300  
1-57

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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

|  |                                  |   |  |  |   |
|--|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Marion</u>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Illinois</u> b. COUNTY <u>Adams</u> |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><u>Hannibal</u>   |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN<br><u>Fall Creek</u>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                         |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>St Elizabeth Hos.</u>  |                                  | Length of stay in 1b<br><u>2 wks</u>  | d. STREET ADDRESS (If outside, give location)  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                        |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Leona</u> Middle _____ Last <u>Miller</u>   |                                  |   | 4. DATE OF DEATH<br>Month <u>Nov</u> Day <u>2</u> Year <u>1958</u>   |  |   |
| 5. SEX<br><u>female</u>  | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Apr 5, 1897</u>   | 9. AGE (In years last birthday)<br><u>61</u>   | IF UNDER 1 YEAR<br>Months _____ Days _____  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housework</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>own home</u>  | 11. BIRTHPLACE (City and state or country)<br><u>Pike County, Illinois</u>   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   |
| 13a. FATHER'S NAME<br><u>Joseph Meyer</u>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Mollie Glass</u>  |  | 14. NAME OF HUSBAND OR <del>WIFE</del><br><u>not given</u>                           |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>not given</u>   | 17. INFORMANT<br>Address<br><u>Mrs. Anna Bailey, Payson, Illinois</u>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u>  |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>18 days</u>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |                                  |   |  |  |   |
| 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?<br>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.)<br><u>330X</u>                              |  |   |
| 20c. TIME OF INJURY<br>Hour _____ 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>10-18-58</u> to <u>11-2-58</u> and last saw her alive on <u>11-2-58</u><br>Death occurred at <u>5:55 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |  |  |   |
| 22a. SIGNATURE<br><u>Earl P. Kapp</u> (Degree or title)<br><u>MD</u>   |                                  | 22b. ADDRESS<br><u>1001 Bdway, Hannibal, Mo</u>   |  | 22c. DATE SIGNED<br><u>11-3-58</u>   |   |
| 23a. BURIAL, CREMATION, REPOSY (Specify)<br><u>burial</u>  |                                  | 23b. DATE<br><u>Nov 5, 1958</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St Anthony Cem</u>  | 23d. LOCATION (City, town, or county) (State)<br><u>Melrose Twp, Adams, Illinois</u> |   |
| 24. FUNERAL DIRECTOR<br><u>W.C. Crossgrove</u>   |                                  | ADDRESS<br><u>Payson, Mo</u>  | 25. DATE RECD. BY LOCAL REG.<br><u>11-4-58</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Dr. E.M. Tucker, Payson, Mo</u>                      |   |

NOV 12 1958  
RECEIVED  
MARION CO. HEALTH DEPT.  
DATE FILED NOV 12 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 *John S Ward* .....

Licensed Embalmer No. *4140*  
P. O. Address *Humboldt, 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.