

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002113

STATE FILE NUMBER

FILED JAN 28 1959

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <u>Merion</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 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>6644 Mount Olivet Heights</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LORETTA</u> Middle <u>MABEL</u> Last <u>HELBING</u>			4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1959</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 type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>February 22, 1887</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>19</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>Near, Madison Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13a. FATHER'S NAME <u>James E. Bell</u>		13b. MOTHER'S MAIDEN NAME <u>Mildred Bradley</u>		14. NAME OF HUSBAND OR WIFE <u>J. Ernest Helbing</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. Hugo A. Alexander 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>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arterio Sclerotic Vasculat Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Parkeinson Disease - 10 yrs.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>supra.</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>-</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>Jan. 9, 1959</u> to <u>Jan. 11, 1959</u> and last saw her alive on <u>Jan. 10, 1959</u> - Death occurred at <u>10 A.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Robert J. Lanning M.D.</u> (Name or title)			22b. ADDRESS <u>Hannibal, Mo</u>		22c. DATE SIGNED <u>1/11/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1/14/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u>		23d. LOCATION (City, town, or county) <u>Hannibal Missouri</u>
24. FUNERAL DIRECTOR <u>W. Crawford Smith Hannibal Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>1/13/59</u>		26. REGISTRAR'S SIGNATURE <u>W. M. Lucke Reg. H. C. Fisher</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

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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.

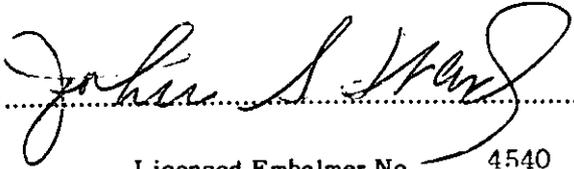
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

RECEIVED JAN 26 1959
MARION CO. HEALTH DEPT.
DATE FILED Jan 26 1959

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. 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.