

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH59-010177
STATE FILE NUMBER

FILED MAR 23 1959 Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 80

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Hannibal
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Levering Hospital		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Marion Hotel
3. NAME OF DECEASED (Type or print) First Middle Last Winfield C. Smith			4. DATE OF DEATH Month Day Year 3/17/1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/17/1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Line Man (Retired)		10b. KIND OF BUSINESS OR INDUSTRY C.B. & Q. RR. Co.	11. BIRTHPLACE (City and state or country) Mechanicsburg, Penn.
13a. FATHER'S NAME Daniel Smith		13b. MOTHER'S MAIDEN NAME Elizabeth Stot	14. NAME OF HUSBAND OR WIFE Maud Smith
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT Address Mrs. Geneva Walley, 306 N. Arch St.,
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hannibal, Mo. Intercranial bleeding DUE TO (b) Hypertensive cardio vascular disease DUE TO (c) ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 days
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 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 Hannibal Marion Missouri	
21. I attended the deceased from 3/15/59 to and last saw her alive on 3/17/59 Death occurred at 7:50 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Walterscheid M. D.		22b. ADDRESS 508 Broadway, Hannibal, Mo.	22c. DATE SIGNED 3/18/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3/19/59	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION (City, town, or county) (State) Quincy, Illinois
24. FUNERAL DIRECTOR ADDRESS H. M. O'Donnell, Hannibal, Mo.		25. DATE RECD. BY LOCAL REG. 3-19-59	26. REGISTRAR'S SIGNATURE Dr. Em Lucke By Walterscheid

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *J. M. O'Donnell*

Licensed Embalmer No. 3889

P. O. Address Hannibal, 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.