...OURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–033056
STATE FILE NUMBER

FILED VS OCT 8 1959

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 307

AMENDED

1. PLACE OF DEATH
a. COUNTY: Marion
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Hannibal — Length of stay in 1b:
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Clark's Rest Home — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Marion
c. CITY OR TOWN: Hannibal — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 515 Riverside Street — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: FRANKIE Middle: Last: GIRARD
4. DATE OF DEATH: Month: October Day: 5 Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 2/20/1879
9. AGE (last birthday): 80
IF UNDER 1 YEAR: Months: 7 Days: 15
IF UNDER 24 HR: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: International Shoe
11. BIRTHPLACE (City and state or country): Evansville Missouri
12. CITIZEN OF WHAT COUNTRY: U S A
13a. FATHER'S NAME: George Walker
13b. MOTHER'S MAIDEN NAME: Mary Mayes
14. NAME OF HUSBAND OR WIFE: Raphael A. Girard (Dec)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs. Guy Bell, Hunnewell Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
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): Complete Heart Block.
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☒ ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.): —
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year: —
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Aug 21, 1959, to October 5, 1959 and last saw her/him alive on Sept 15, 1959
Death occurred at 7:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Robert J. Lanning M.D. (Degree or title)
22b. ADDRESS: Hannibal Mo.
22c. DATE SIGNED: 10-6-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE
23c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery
23d. LOCATION (City, town, or county) (State): Moberly Missouri

24. FUNERAL DIRECTOR: W. Crawford Smith ADDRESS: Hannibal Missouri
25. DATE RECD. BY LOCAL REG.: 10-6-59
26. REGISTRAR'S SIGNATURE: Dr. E.M. Lucke By W.R. Fisher

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 4540

P. O. Address Hannibal Misso

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.