DURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 1 1959

59–033069

STATE FILE NUMBER

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 294

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: Residence 3914 Market
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): 3914 Market
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: EMMA Middle: BELL Last: PRESTON

4. DATE OF DEATH: Month, Day, Year: September 23, 1959

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 11/13/1861

9. AGE (last birthday): 97

IF UNDER 1 YEAR: Months: 9 Days: 10
IF UNDER 24 HR: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Hancock Cty. Illinois

12. CITIZEN OF WHAT COUNTRY: U S A

13a. FATHER'S NAME: P.D.Williams

13b. MOTHER'S MAIDEN NAME: Margaret Dale

14. NAME OF HUSBAND OR WIFE: J.M.Preston(Deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs.Warren Watts, Hannibal Missouri

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 14 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerosis — 2 years.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

MEDICAL CERTIFICATION

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 Dec 1957, to Sept. 23 1959 and last saw her alive on Sept. 17 1959

Death occurred at 2:45 A. m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Glenn R. Miller MD

22b. ADDRESS: Hannibal Mo

22c. DATE SIGNED: 9-23-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 9/25/1959

23c. NAME OF CEMETERY OR CREMATORY:

23d. LOCATION (City, town, or county) (State): LaHarpe Illinois

24. FUNERAL DIRECTOR ADDRESS: W. Crawford Smith, Hannibal Missouri

25. DATE RECD. BY LOCAL REG.: 9-23-1959

26. REGISTRAR'S SIGNATURE: Dr. E. M. Luke by H. C. Fisher

BY AFFIDAVIT OF

DOCUMENT

(Licensed Embalmer's Statement on Reverse Side)

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_____
Signature of Student Embalmer

Signed John S Ford

, Licensed Embalmer No. 4540

P. O. Address Hannibal Missour

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.