

Dr. Walterscheid
 URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036884

FILED VS OCT 29 1959

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 329

UNDECEASED

1. PLACE OF DEATH a. COUNTY <u>Marion</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>		c. CITY OR TOWN <u>Hannibal</u>	
Length of stay in lb		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</u>		d. STREET ADDRESS (If outside, give location) <u>Marion Hotel</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Onas</u> Middle <u>Dowell</u> Last			4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/9/1890</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer-Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Rolls Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>G. B. Dowell</u>	13b. MOTHER'S MAIDEN NAME <u>Fannie E. Rose</u>	14. NAME OF HUSBAND OR WIFE <u>- - -</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>	16. SOCIAL SECURITY NO. <u>WW I</u>	17. INFORMANT <u>Raymond R. Dowell, Bowling Green</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		Mo.	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>			<u>7 days</u>
DUE TO (b) <u>duodenal ulcer</u>			<u>30 day</u>
DUE TO (c) <u>diabetes mellitus</u>			<u>10 yrs</u>

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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? 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.)
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. Month, Day, Year		

20d. INJURY OCCURRED WHILE AT WORK <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.) <u>Hannibal, Marion, Mo.</u>	20f. CITY, TOWN, OR LOCATION <u>Hannibal, Marion, Mo.</u>	COUNTY <u>Marion</u>	STATE <u>Mo.</u>
21. I attended the deceased from <u>9/13/59</u> to <u>10/12/59</u> and last saw him alive on <u>10/12/59</u> Death occurred at <u>11:10 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>J. H. Walterscheid M.D.</u>	22b. ADDRESS <u>508 Broadway, Hannibal, Mo.</u>	22c. DATE SIGNED <u>10/26/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/14/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hays Creek Cemetery</u>
23d. LOCATION (City, town, or county) <u>Rolls County, Mo.</u>		(State)

24. FUNERAL DIRECTOR <u>H. M. O'Donnell, Hannibal, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10/27/59</u>	26. REGISTRAR'S SIGNATURE <u>J. E. M. Lucke By J. H. Walterscheid</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wm. 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.