

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 5 1960

=60-002521

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 42 STATE FILE NUMBER

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>		Length of stay in 1b		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>Beth Haven Rest Home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>508 Wilson Avenue</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>C.</u> Last <u>MCDONALD</u>				4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>1960</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>April 3, 1885</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>28</u> Days <u>28</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR.		
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>Pettis Conty Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13a. FATHER'S NAME <u>James Monroe Christopher</u>			13b. MOTHER'S MAIDEN NAME <u>Rebecca Jane Vault</u>			14. NAME OF HUSBAND OR WIFE <u>John W. McDonald (Deceased)</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>XX</u> (If yes, give war or dates of service) <u>XX</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Roy McDonald, 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 thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
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)					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			
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 _____ a.m. _____ 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <u>1/15/60</u> to <u>1/21/60</u> and last saw her/him alive on <u>1/21/60</u> Death occurred at <u>6:00</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>J. Roller</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>Hannibal, Missouri</u>		22c. DATE SIGNED <u>Feb 2/60</u>		
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/2/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Park</u>		23d. LOCATION (City, town, or county) <u>Hannibal Missouri</u>				
24. FUNERAL DIRECTOR <u>J. Crawford Smith, Hannibal Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>2/3/60</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E.M. Lucke by Lillian M. Norman</u>			

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W Crawford Smith

Licensed Embalmer No. 7814

P. O. Address Hannibal Miss

**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.