

JR. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-020103

FILED VS MAY 19 1960

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 180

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 checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Leveering Hosp.</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>515 OLIVE ST.</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle <u>HART</u> Last <u>HART</u> | | | | 4. DATE OF DEATH Month <u>5</u> - Day <u>7</u> - Year <u>60</u> | | | | |
| 5. SEX <u>Male</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>8-4-1895</u> | 9. AGE (last birthday) <u>64</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>CANTON, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>KIRT HART</u> | | | 13b. MOTHER'S MAIDEN NAME <u>RUSSIE PORTER</u> | | | 14. NAME OF HUSBAND OR WIFE <u>LAUENIA HART</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W.I</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>MRS. CLIFFORD PRICE, HANNIBAL, MO.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> | | | | | | | <u>4 days</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) <u>Aspiration pneumonia</u> | | | | | 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>8-1-46</u> to <u>5-7-60</u> and last saw him ^{XXX} alive on <u>5-7-60</u> Death occurred at <u>1:25 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) | | | | 22b. ADDRESS <u>M. D. 100 N. Sixth, Hannibal, Mo.</u> | | | 22c. DATE SIGNED <u>5-11-60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>5-9-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>GRAND VIEW BURIAL P.</u> | | 23d. LOCATION (City, town, or county) <u>HANNIBAL, Mo.</u> | | | (State) |
| 24. FUNERAL DIRECTOR <u>Jack Helwig - Hannibal Mo.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>5-13-60</u> | | 26. REGISTRAR'S SIGNATURE <u>Dr. E.M. Puske by Helwig</u> <u>M. A. Herman</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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Just Schwarz*
Licensed Embalmer No. 4900
P. O. Address Hamburg

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