URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-031346

FILED VS SEP 14 1960

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 366

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH
a. COUNTY: Marion
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Hannibal
Length of stay in 1b: 3 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Beth Haven Nursing Home
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Marion
c. CITY OR TOWN: Hannibal
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 914 Hill St
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Myrtle Middle: Adeline Last: Piper
4. DATE OF DEATH: Month 9 Day 19 Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 7-16-80
9. AGE (last birthday): 80
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: (Own home)
11. BIRTHPLACE (City and state or country): Hannibal, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: John Warner
13b. MOTHER'S MAIDEN NAME: Ann Jane Lidenton
14. NAME OF HUSBAND OR WIFE: James Piper
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ann Wells Address: Hannibal, Mo.

MEDICAL CERTIFICATION

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)	Cerebral hemorrhage (massive)	36 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Hypertensive heart disease	15 yrs.
DUE TO (c)	Diabetes mellitus	20 yrs.

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

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 Jan-1-1959 to Sept. 10-1960 and last saw her alive on Sept. 10-1960
Death occurred at 8:45 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: E.G. Porter D.O. (Degree or title)
22b. ADDRESS: 412 Center St., Hannibal, Mo
22c. DATE SIGNED: 9/12/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9-11-1960
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town, or county) (State): Hannibal, Mo.

24. FUNERAL DIRECTOR: Clark Funeral Home ADDRESS: Hannibal, Mo.
25. DATE RECD. BY LOCAL REG.: 9/12/60
26. REGISTRAR'S SIGNATURE: Dr. E.M. Lucke by Lillian M. Herman

(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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Ralph Clark

Signature of Student Embalmer

Licensed Embalmer No. 4217

P. O. Address Hannibal, Mo

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