

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035490

FILED VS. SEP 28 1960

209

Registration District No. 209 Primary Registration District No. 3043

Registrar's No. 381

STATE FILE NUMBER

|   |  |   |   |   |  |  |  |  |  |
|---|--|---|---|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Marion</b>  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>Marion</b>                        |  |  |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Hannibal</b>  |  | Length of stay in 1b<br><b>DOA</b>  |   | c. CITY OR TOWN <b>Hannibal</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |  |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Levering Hospital</b>   |  |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  | d. STREET ADDRESS (If outside, give location)<br><b>1616 E Gordon St</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>H.</b> Last <b>Doerge</b>   |  |   |   | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>17</b> Year <b>1960</b>   |  |  |  |  |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>   |   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>7-23-87</b>  |  |  |  |
| 9. AGE (last birthday) <b>73</b>  |  | IF UNDER 1 YEAR<br>Months Days  |   | IF UNDER 24 HR<br>Hours Min.  |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Custodian</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>School System</b> |   | 11. BIRTHPLACE (City and state or country)<br><b>Mexico, Mo.</b> |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |  |  |
| 13a. FATHER'S NAME<br><b>John Doerge</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Unknown</b>               |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Pauline Doerge</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   | 16. SOCIAL SECURITY NO.                                   |   | 17. INFORMANT<br>Address<br><b>Pauline Doerge Hannibal, Mo.</b>  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO (b) <b>duodenal ulcer</b><br>DUE TO (c) <b>Diabetis Mellitus</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Instantly</b><br><b>3 months</b><br><b>years.</b> |  |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour Month, Day, Year<br>a.m. p.m.   |  |   |   |   |  |  |  |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 20f. CITY, TOWN, OR LOCATION<br><b>Hannibal, Marion, Mo.</b>  |  | COUNTY   |  | STATE  |  |
| 21. I attended the deceased from <b>9/17/60</b> to _____ and last saw her/him alive on <b>8/24/60</b><br>Death occurred at <b>4:15 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.   |  |   |   |   |  |  |  |  |  |
| 22a. SIGNATURE<br><i>W. H. ... M.D.</i> (Degree or title)   |  |   |   | 22b. ADDRESS<br><b>1209 Broadway, Hannibal, Mo.</b>   |  |  | 22c. DATE SIGNED<br><b>9/20/60</b>   |  |  |
| 23a. BURIAL / CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>9-19-1960</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Grand View Cemetery</b>  |  | 23d. LOCATION (City, town, or county)<br><b>Hannibal, Mo.</b>  |  | (State)  |  |
| 24. FUNERAL DIRECTOR<br><b>Clark Funeral Home - Hannibal, Mo.</b>   |  |   |   | ADDRESS   |  | 25. DATE RECD. BY LOCAL REG.<br><b>9/22/60</b>   |  | 26. REGISTRAR'S SIGNATURE<br><i>Dr. E. M. Rucke by Lillian M. Norman</i> |  |

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 

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 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.