

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035501

FILED VS SEP 28 1960

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 374

1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</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>ST. FLIZABETH HOSPITAL</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3507 W. ELY RD</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>LOGAN</u> Last <u>MACKAY</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>15</u> Year <u>1960</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>3-31-03</u>	9. AGE (last birthday) <u>57</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>14</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LEGAL SECRETARY</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>CARSTARPHEN & HARVEY</u>		11. BIRTHPLACE (City and state or country) <u>MARION CY MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>JOHN W. LOGAN</u>			13b. MOTHER'S MAIDEN NAME <u>FANNIE J. SCHUMATE</u>			14. NAME OF HUSBAND OR WIFE <u>STANFORD L. MACKAY</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS RILEY TAPSCOTT 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>Coronary arrest</u>							<u>3 days.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterial aneurysm</u>							<u>3 days.</u>	
DUE TO (c) <u>Infectious abdominal</u>							<u>4 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Recent Cerebral Craniotomy & grossly infected</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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> Month, Day, Year <u></u>								
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>Sept 5, 1960</u> to <u>Sept 15, 1960</u> and last saw her alive on <u>Sept 15, 1960</u> . Death occurred at <u>8:00 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Robert J. Lanning, M.D.</u>				22b. ADDRESS <u>Hannibal, Mo</u>		22c. DATE SIGNED <u>9/17/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>9-17-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LaBELLE CEMETERY</u>		23d. LOCATION (City, town, or county) <u>LaBELLE MISSOURI</u>			
24. FUNERAL DIRECTOR ADDRESS <u>W. CRAWFORD SMITH HANNIBAL MO</u>				25. DATE RECD. BY LOCAL REG. <u>9/16/60</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke by William M. 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

John S. Strand

Licensed Embalmer No.

4540

P. O. Address

Hammaker

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.