

Dr. Lanning  
**R. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS NOV 10 1960

**-60-039007**

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 430

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>		c. CITY OR TOWN <u>Hannibal</u>	
Length of stay in 1b		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>St. Elizabeth Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>1201 Woodrow</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Sandra</u> Middle <u>Caldwell</u> Last	4. DATE OF DEATH Month <u>9</u> Day <u>7</u> Year <u>1960</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/7/60</u>	9. AGE (last birthday)	IF UNDER 1 YEAR Months <u>2</u> Days <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
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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>Hannibal, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Basil Caldwell</u>	13b. MOTHER'S MAIDEN NAME <u>Willila Smith</u>	14. NAME OF HUSBAND OR WIFE <u>- - - -</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mr. Basil Caldwell, 1201 Woodrow</u>	Address
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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>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
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"/> N- <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.)
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20c. TIME OF INJURY Hour <u>1:00</u> a.m. <u>0</u> p.m.	Month, Day, Year
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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	COUNTY	STATE
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at 1:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Charles A. High</u> (Degree or title) <u>MO.</u>	22b. ADDRESS <u>115 N 5th Hannibal, Mo.</u>	22c. DATE SIGNED <u>10-12-60.</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/9/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hope Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Rolla Co., Mo.</u>
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24. FUNERAL DIRECTOR <u>H. M. O'Donnell, Hannibal, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10/28/60</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke by Lillian W. Herman</u>
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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 *A M O'Donnell*

Licensed Embalmer No. 3889

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.