

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042794

FILED VS DEC 7 1960

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 467

STATE FILE NUMBER

DED

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>St. Elizabeth Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>819 Hill Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Benny</u> Last <u>Dorsey</u>				4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jul. 13, 1867</u>	9. AGE (last birthday) <u>93</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Lincoln county</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>George Dorsey</u>			13b. MOTHER'S MAIDEN NAME <u>Matelda ?</u>			14. NAME OF HUSBAND OR WIFE <u>Zella Dorsey</u>	
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. <u>none</u>		17. INFORMANT Address <u>Hannibal, Mo.</u> <u>Mrs. Zella Dorsey 819 Hill Street</u>		
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>Cerebral hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</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)						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 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 <u>him</u> on <u>11/25/60</u> , to _____ and last saw <u>him</u> alive on _____ Death occurred at <u>6:25 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Ink name or title) <u>M. J. Roller, M. D.</u>				22b. ADDRESS <u>2910 St. Marys, Hannibal, Mo.</u>			22c. DATE SIGNED <u>11/28/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 29, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>		23d. LOCATION (City, town, or county) <u>Lincoln county</u>		(State) <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>Geo E Roberts</u> ADDRESS <u>218 Broadway</u>			25. DATE RECD. BY LOCAL REG. <u>11-29-1960</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke by Jullian M. Verman</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 George E. Roberts
George E. Roberts

Licensed Embalmer No. 2113

P. O. Address Hannibal, Missouri

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.