

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042808

FILED VS DEC 7 1960

209

Primary Registration District No. 3043

Registrar's No. 466

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Marion				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Marion				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal		Length of stay in 1b		c. CITY OR TOWN Hannibal		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Shady Lawn Rest Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Shady Lawn Rest Home		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERTHA Middle L. Last OLWIN				4. DATE OF DEATH Month November Day 27 Year 1960				
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH May 26, 1880	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months 4 Days 1	IF UNDER 24 HR Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during, most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Golconda Illinois		12. CITIZEN OF WHAT COUNTRY U S A		
13a. FATHER'S NAME John Abbott			13b. MOTHER'S MAIDEN NAME Conelia Craig		14. NAME OF HUSBAND OR WIFE Fred B. Olwin (Deceased 11/19)			
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. None		17. INFORMANT J. Harold Olwin Hannibal Missouri				
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) General Debility Progressive						6 mo		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Metastatic adenocarcinoma				1 yr		
		DUE TO (c) Adeno Carcinoma - Sigmoid				1 yr		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Ununited Fracture Rt Hip - 2 yrs						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 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 Hour 10:35 AM Month, Day, Year 1958		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		
21. I attended the deceased from 1958 to Nov. 27-60 and last saw her ^{her} _{him} alive on Nov. 26-60 Death occurred at 10:35 AM on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE F. E. Suetzman M.D. (Degree or title)				22b. ADDRESS HANNIBAL MO		22c. DATE SIGNED 11-26-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/29/1960	23c. NAME OF CEMETERY OR CREMATORY Robinson Cemetery		23d. LOCATION (City, town, or county) Robinson Illinois		(State)	
24. FUNERAL DIRECTOR V. Crawford Smith Hannibal Missouri				25. DATE RECD. BY LOCAL REG. 11/28/60		26. REGISTRAR'S SIGNATURE Dr. E. D. Lucke by Lillian M. Norman		

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. Spang

Licensed Embalmer No. 4540

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.