

Dr. Murphy
FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS DEC 29 1960

-60-046819

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 506 STATE FILE NUMBER

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 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>1111 Walnut St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>B.</u> Last <u>Kane</u>				4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1960</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>6/11/1876</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </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>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Pittsfield, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Patrick Killian</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Ann Reed</u>			14. NAME OF HUSBAND OR WIFE <u>Patrick Kane</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.		17. INFORMANT <u>Mrs. Richard Broemmer</u>			Address	
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>Bronchial pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
DUE TO (b) <u>Arteriosclerotic heart disease with decompensation</u>						unknown			
DUE TO (c) <u>Diabetes mellitus</u>						8 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Comminuted fracture distal third left femur</u>						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 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.) <u>fell out of bed</u>						
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u>10/ 6/60</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.) <u>Rest Home</u>		20f. CITY, TOWN, OR LOCATION <u>Hannibal</u>		COUNTY <u>Marion</u>		STATE <u>Missouri</u>	
21. I attended the deceased from <u>4/7/60</u> to <u>12/15/60</u> and last saw her/him alive on <u>12/14/60</u> . Death occurred at <u>12:40 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>100 N. 6th, Hannibal, Mo.</u>			22c. DATE SIGNED <u>12/21/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/17/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Hannibal, Mo.</u>			
24. FUNERAL DIRECTOR <u>H.M.O'Donnell, Hannibal, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>12/27/60</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E.M. Lucke by Lillian 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 W. 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 conform 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.