

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-009762  
STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 130

FILED APR 7 1961

1. PLACE OF DEATH a. COUNTY <b>Marion</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Marion</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>		c. CITY OR TOWN <b>Hannibal</b>	
Length of stay in 1b <b>30 yrs.</b>		Inside Limits <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. St. Elizabeth</b>		d. STREET ADDRESS (If outside, give location) <b>1814 Valley St.</b>	
Yes <input 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 <b>JOSEPHINE</b> Middle <b>E.</b> Last <b>GENOVESE</b>			4. DATE OF DEATH Month <b>3</b> Day <b>30</b> Year <b>61</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-30-11</b>	9. AGE (last birthday) <b>49</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>	11. BIRTHPLACE (City and state or country) <b>Monroe City, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Aaron Cummings</b>	13b. MOTHER'S MAIDEN NAME <b>Eileen Shaver</b>	14. NAME OF HUSBAND OR WIFE <b>Frank Genovese</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT <b>Hannibal, Mo. Frank Genovese, 1814 Valley,</b>
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18. CAUSE OF DEATH (Enter only one line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b>
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 checked="" 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 _____ a.m. _____ p.m. _____	Month, Day, Year
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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 <b>Hannibal</b>	COUNTY <b>Marion</b>	STATE <b>Mo.</b>
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21. I attended the deceased from **3-29-61** to **3-30-61** and last saw her <sup>her</sup> ~~NO~~ alive on **3-30-61**  
Death occurred at **10:30 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	(Degree or title) <b>MD</b>	22b. ADDRESS <b>100 N 6th St Hannibal</b>	22c. DATE SIGNED <b>4/3/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4-3-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	23d. LOCATION (City, town, or county) <b>Hannibal, Mo.</b>
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24. FUNERAL DIRECTOR <b>Jack Schwartz - Hannibal Mo.</b>	ADDRESS <b>Hannibal Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>4-4-61</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *John Schwart*

Licensed Embalmer No. 4900

P. O. Address Honolulu,

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.