

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-033613

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 318

STATE FILE NUMBER

AMENDED DATE AMENDED INSTEAD OF DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF ITEM NO. SHOULD READ

FILED SEP 28 1961

1. PLACE OF DEATH
 a. COUNTY **Marion**
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **Hannibal** Length of stay in lb
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **St. Elizabeth Hospital** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **Missouri** COUNTY **Marion**
 c. CITY OR TOWN **Hannibal** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) **914 Reservoir** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
Allison F. Smith

4. DATE OF DEATH Month Day Year
9/13/1961

5. SEX **Male** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH **5/9/1894** 9. AGE (last birthday) **67** IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Contractor** 10b. KIND OF BUSINESS OR INDUSTRY **Roofing Co.** 11. BIRTHPLACE (City and state or country) **Mt. Sterling, Ill** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **Oliver Smith** 13b. MOTHER'S MAIDEN NAME **Johanna Farrell** 14. NAME OF HUSBAND OR WIFE **Doris Smith**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **Yes WW I** 16. SOCIAL SECURITY NO. **WW I** 17. INFORMANT Address **Mrs. Doris Smith, 914 Reservoir**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Coronary Thrombosis** Hannibal, Mo. INTERVAL BETWEEN ONSET AND DEATH **30 min.**
 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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 _____ to _____ and last saw her/him alive on _____
 Death occurred at **11:05 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE **[Signature]** (Degree or title) 22b. ADDRESS **100 N 6th St** 22c. DATE SIGNED **9/14/1961**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE **9/15/1961** 23c. NAME OF CEMETERY OR CREMATORY **St. Mary's Cemetery** 23d. LOCATION (City, town, or county) (State) **Hannibal, Mo.**

24. FUNERAL DIRECTOR ADDRESS **H. M. O'Donnell, Hannibal, Mo.** 25. DATE RECD. BY LOCAL REG. **9/20/61** 26. REGISTRAR'S SIGNATURE **Dr. E. M. Lucke by Lillian A. Herman**

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 *A. M. O'Connell*

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.