SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-041741
STATE FILE NUMBER

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 395

FILED NOV 21 1961

1. PLACE OF DEATH
a. COUNTY Marion
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 518 Olive Street — Inside Limits Yes X No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Marion
c. CITY OR TOWN Hannibal — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) 518 Olive — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First: ANNA Middle: MAE Last: MILLER
4. DATE OF DEATH Month: Nov. Day: 9 Year: 1961
5. SEX: F
6. COLOR OR RACE: W
7. Married X Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Dec 17 04
9. AGE (last birthday): 56 — IF UNDER 1 YEAR Months: 10 Days: 22 — IF UNDER 24 HR Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (City and state or country): Moberly Missouri
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: William Warden
13b. MOTHER'S MAIDEN NAME:
14. NAME OF HUSBAND OR WIFE: Verle Miller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Verle Miller Address: Hannibal Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: acute
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): auricular fibrillation — 6 yrs
DUE TO (c): cardiomegalia with valvular heart disease — 6 yrs

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 X No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO X
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 Sept 1956, to June 1961 and last saw her alive on June 1961
Death occurred at 6:00A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE F. C. Dultzman M.D. (Degree or title)
22b. ADDRESS 115 N. 5th St, Hannibal, Missouri
22c. DATE SIGNED Nov 10,61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Nov 11 1961
23c. NAME OF CEMETERY OR CREMATORY: Grand View Burial Park
23d. LOCATION (City, town, or county) (State): Hannibal ~~Rall~~ Missouri

24. FUNERAL DIRECTOR ADDRESS: Smith's Funeral Home Hannibal Mo.
25. DATE RECD. BY LOCAL REG.: Nov. 11-1961
26. REGISTRAR'S SIGNATURE: Lillian M Herman

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | 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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 4540

P. O. Address Hannibal Missou

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl 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.