

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-011924

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 100

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 26 1962							
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Marion</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u> Length of stay in 1b _____</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Levering Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u></p> <p>c. CITY OR TOWN <u>Hannibal</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>516 Center</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>						
<p>3. NAME OF DECEASED (Type or print) First Middle Last</p> <p style="text-align: center;"><u>ELIZABETH LETHA GLEESON</u></p>							
<p>4. DATE OF DEATH Month Day Year</p> <p style="text-align: center;"><u>March 16 1962</u></p>							
<p>5. SEX <u>Female</u></p>	<p>6. COLOR OR RACE <u>White</u></p>	<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>Jan 15 1880</u></p>	<p>9. AGE (last birthday) <u>82</u></p>	<p>IF UNDER 1 YEAR Months <u>2</u> Days <u>1</u></p> <p>IF UNDER 24 HR Hours _____ Min. _____</p>		
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY _____</p>		<p>11. BIRTHPLACE (City and state or country) <u>Pike County Mo</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>U S A</u></p>	
<p>13a. FATHER'S NAME <u>A. J. Crank</u></p>			<p>13b. MOTHER'S MAIDEN NAME <u>Sallie Pamplin</u></p>		<p>14. NAME OF HUSBAND OR WIFE <u>Frank W. Gleeson</u></p>		
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u></p>			<p>16. SOCIAL SECURITY NO. _____</p>		<p>17. INFORMANT <u>Mrs. E. E. Moehlman</u> Address <u>New Mendon Ill</u></p>		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____</p> <p>DUE TO (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____</p> <p>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</p>							
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____</p>			
<p>20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>		<p>20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____</p>	
<p>21. I attended the deceased from <u>Feb 14 / 62</u> to <u>March 16 / 62</u> and last saw her alive on <u>16 March / 62</u></p> <p>Death occurred at <u>7:30 P</u> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.</p>							
<p>22a. SIGNATURE <u>[Signature]</u> (Degree or title) _____</p>			<p>22b. ADDRESS <u>Hannibal Mo</u></p>		<p>22c. DATE SIGNED <u>17 March / 62</u></p>		
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>23b. DATE <u>3/19/1962</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Park</u></p>		<p>23d. LOCATION (City, town, or county) <u>Hannibal Missouri</u></p>	
<p>24. FUNERAL DIRECTOR <u>Smith's Funeral Home</u> ADDRESS <u>Hannibal Missouri</u></p>			<p>25. DATE RECD. BY LOCAL REG. <u>March 19, 1962</u></p>		<p>26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Roche by Tilban M. Newman</u></p>		

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

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 S. Star

Licensed Embalmer No. 4540

P. O. Address Hannibal Missouri

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.

Permit to Burial 3/19/62