

Dr. Walterscheid
MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-032915

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 270

STATE FILE NUMBER

FILED AUG 26 1963

DO NOT WRITE ON THIS STUB	AMENDED	DATE AMENDED	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
VS 300 Rev. 4/59					
1 0648					
2 0648					
3					
4 1					
5 2					
6					
7 1					
8 2					
9 420.1					
10					
11					
12 86-0					
13 1-1					
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	SHOULD READ			
USE BLACK INK OR TYPEWRITER RIBBON					

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> 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>Shady Lawn Rest Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1235 Church</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Laura</u> Last <u>Brooks</u>			4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1963</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>Jun. 18, 1869</u>	9. AGE (last birthday) <u>94</u>	IF UNDER 1 YEAR Months Days Hours Min.
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>Moweaqua, Ill.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Randall R. Adams</u>		13b. MOTHER'S MAIDEN NAME <u>Mary E. Northcutt</u>		14. NAME OF HUSBAND OR WIFE <u>Stephen Brooks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Fairalee F. Tapley, 1235 Church, Hannibal, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION</u>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <u>ARTERIOSCLEROSIS</u>					
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 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.)	
20c. TIME OF INJURY Hour <u> </u> a.m. / p.m. Month, Day, Year <u> </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.)		20f. CITY, TOWN, OR LOCATION <u>Hannibal Marion Mo</u>	
				COUNTY <u> </u> STATE <u> </u>	
21. I attended the deceased from <u>5/28/63</u> to <u>6/11/63</u> and last saw her alive on <u>6/11/63</u> Death occurred at <u>8:15 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>J. H. Walterscheid M.D.</u>			22b. ADDRESS <u>1209 Broadway, Hannibal, Mo.</u>		22c. DATE SIGNED <u>7/29/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 29, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Old Stonington Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Old Stonington, Ill.</u>
24. FUNERAL DIRECTOR <u>H.M. O'Donnell, Hannibal, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Aug. 9, 1963</u>		26. REGISTRAR'S SIGNATURE <u>Mr. E. M. Rusche by William M. Herman</u>

MISSOURI - HANNIBAL

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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 J. 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 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 renewed 7-21-23