No. 300
10.48

FILED JUL 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24031

State File No.

BIRTH NO. REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 245

1. PLACE OF DEATH a. COUNTY Marion Lovering Hospital
b. CITY OR TOWN Hannibal c. LENGTH OF STAY (In this place) 8 yr
d. FULL NAME OF HOSPITAL OR INSTITUTION Lovering Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Marion
c. CITY OR TOWN Hannibal 0644
d. STREET ADDRESS 251 Summit St

3. NAME OF DECEASED (Type or Print) a. (First) Lulu b. (Middle) M. c. (Last) Clay

4. DATE OF DEATH (Month) July (Day) 14th (Year) 50

5. SEX Female **6. COLOR OR RACE** Colored **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify) Widowed **8. DATE OF BIRTH** March 19, 1872 **9. AGE** (In years last birthday) 8 yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home work **10b. KIND OF BUSINESS OR INDUSTRY** **11. BIRTHPLACE** (State or foreign country) Hannibal C **12. CITIZEN OF WHAT COUNTRY?** U.S.A.

13a. FATHER'S NAME Oswald Carrington **13b. MOTHER'S, MAIDEN NAME** Celia Hutchinson **14. NAME OF HUSBAND OR WIFE**

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'S SIGNATURE OR NAME** Lois Ewing **ADDRESS** 251 Summit Hannibal

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Mitral Insufficiency

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

4 yrs

19a. DATE OF OPERATION **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) **21b. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) **21c. (CITY, TOWN, OR TOWNSHIP)** (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. **21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐ **21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* 7-2, 1950, *to* 7-14, 1950, *that I last saw the deceased alive on* 7-14, 1950, *and that death occurred at* 9:59 m., *from the causes and on the date stated above.*

23a. SIGNATURE G. W. Todd M.D. (Degree or title) **23b. ADDRESS** Hannibal Mo **23c. DATE SIGNED** 7-17-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial **24b. DATE** 7-18-50 **24c. NAME OF CEMETERY OR CREMATORY** Robinson Cemetery **24d. LOCATION** (City, town, or county) Hannibal (State) Mo.

DATE REC'D BY LOCAL REG. 7/18/50 **REGISTRAR'S SIGNATURE** H. E. Mucke County Clerk **25. FUNERAL DIRECTOR'S SIGNATURE** R. Siphus **ADDRESS** Hannibal Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED JUL 20 1950
ALLEGHENY CO. HEALTH DEPT.
DATE FILED JUL 22 1950

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 .....
Student Embalmer

Signed W. R. Sephus

Licensed Embalmer No. 3420

P. O. Address 1631 Market Hun

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 this body is not embalmed, fact should be so stated above.