

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1837

FILED JAN 22 1951

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3042 Registrar's No. 14

D644

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal	c. LENGTH OF STAY (In this place) 12/30/50	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal	
d. FULL NAME OF HOSPITAL OR INSTITUTION Levering Hosp.		d. STREET ADDRESS (If rural, give location) 421 Olive Street	

3. NAME OF DECEASED (Type or Print) a. (First) Frederick W. Rather b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) January 14, 1951		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 1, 1874		9. AGE (In years last birthday) Months Days 76 6 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cigar Maker		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Hannibal Missouri		12. CITIZEN OF WHAT COUNTRY? U S A

Relax

13a. FATHER'S NAME Frederick Rather		13b. MOTHER'S MAIDEN NAME Gertrude Jacobs		14. NAME OF HUSBAND OR WIFE Georgia Boren Rather	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 486-20-2001	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Fre. Rather Hannibal Missouri		

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) <u>Coronary occlusion</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary sclerosis</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 4201
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 6, 1951, to Jan 14, 1951, that I last saw the deceased alive on Jan 13, 1951, and that death occurred at 1:40 am., from the causes and on the date stated above.

23a. SIGNATURE M. J. Boenigk M.D.		23b. ADDRESS Hannibal Mo	23c. DATE SIGNED Jan 15/51
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/16/51	24c. NAME OF CEMETERY OR CREMATORY Shelbina	24d. LOCATION (City, town, or county) (State) Shelbina Missouri

DATE REC'D BY LOCAL REG. 1-16-51	REGISTRAR'S SIGNATURE Dr. E. Producers	25. FUNERAL DIRECTOR'S SIGNATURE W. Campbell Smith	ADDRESS Hannibal Missouri
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED JAN 18 1951
MISSOURI HEALTH DEPT.
DATE FILED JAN 20 1951

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.....

.....
working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed.....

John S. Ward

Licensed Embalmer No.....1540.....

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