

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **2012**  
Registrar's No. **2**

FILED JAN 11 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3043**

1. PLACE OF DEATH a. COUNTY <b>Marion</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Ralls</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Hannibal</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>New London</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Levering</b>		d. STREET ADDRESS (If rural, give location) <b>RFD # 2</b>	

3. NAME OF DECEASED (Type or Print) <b>William Cozad</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>January 2, 1952</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>About 60 years old</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmhand</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>XX</b>	11. BIRTHPLACE (State or foreign country) <b>Anawona Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>William Cozad</b>		13b. MOTHER'S MAIDEN NAME <b>Linda Meade</b>	14. NAME OF HUSBAND OR WIFE <b>Deceased</b>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Frank Cozad, Muscatine Iowa</b>		ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>myocardial infarction</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) <b>Janine Bronchogenic Ca</b> DUE TO (c) <b>Julia</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Pulmonary emphysema</b>		6-Month	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) <b>Hannibal Marion Mo</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>162X</b>	

22. I hereby certify that I attended the deceased from **6/1/50**, 19\_\_\_, to **1/2/52**, 19\_\_\_, that I last saw the deceased alive on **1/1/52**, 19\_\_\_, and that death occurred at **9:30 Am.**, from the causes and on the date stated above.

23a. SIGNATURE <b>J. H. Watterling, M.D.</b>	(Degree or title)	23b. ADDRESS <b>508 Broadway Hannibal</b>	23c. DATE SIGNED <b>1/4/52</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>1/4/1952</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet</b>	24d. LOCATION (City, town; or county) (State) <b>Hannibal Missouri</b>

DATE REC'D BY LOCAL REG. <b>1-7-52</b>	REGISTRAR'S SIGNATURE <b>W E M Luckie</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>W Crawford Smith</b>	ADDRESS <b>Hannibal Mo</b>
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WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

0644

RECEIVED JAN 8 1952  
MARION CO. HEALTH DEPT.  
DATE FILED JAN 8 1952

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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 .....  
Student Embalmer

Signed

*John S. Ward*

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