

FILED JUN 17 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19673**

BIRTH NO. _____		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>3043</u>		Registrar's No. <u>463</u>		
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> b. COUNTY <u>Audrain</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hannibal</u>			c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Vandalia</u>			d. STREET ADDRESS (If rural, give location) <u>414 West Highway</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Elizabeth's Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>414 West Highway</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Fannie</u>			b. (Middle) <u>May</u>	c. (Last) <u>Sutton</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 4, 1954</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Aug 10, 1868</u>		9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 M. RES. 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 <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Farber, Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13a. FATHER'S NAME <u>Joe Clark</u>			13b. MOTHER'S MAIDEN NAME <u>Belle Toliver</u>		14. NAME OF HUSBAND OR WIFE <u>Sam Sutton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or date of service) <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Grover Sutton, Vandalia, Missouri</u>				
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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hemorrhage, Stomach Shock</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Probable CARCINOMA Stomach</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Recent fracture RT hip</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>?</u> <u>3 weeks</u>	
19a. DATE OF OPERATION <u>5/18/54</u>	19b. MAJOR FINDINGS OF OPERATION <u>fracture RT hip; also RT femur approx 1/3. 151 x F</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Vandalia AUDRAIN Mo</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>May 16 54 8:30 a.m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>got up from chair and fell to floor</u>				
22. I hereby certify that I attended the deceased from _____, 19____, to <u>6/4/54</u> , 19____, that I last saw the deceased alive on <u>6/4/54</u> , 19____, and that death occurred at <u>5:30 a.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Ervin Phoenix MD</u>				23b. ADDRESS <u>Vandalia, Mo</u>		23c. DATE SIGNED <u>6/5/54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>June 6, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Farber Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Farber, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>6/8/54</u>		REGISTRAR'S SIGNATURE <u>W. C. Fisher</u>		FUNERAL DIRECTOR'S SIGNATURE <u>William B. Walters</u>		ADDRESS <u>Vandalia, Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

JUN 15 1954

RECEIVED

MARION CO. HEALTH DEPT.

DATE FILED JUN 15 1954

FEB 15 1955

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 *William B. Graters*

Licensed Embalmer No. *4169*

P. O. Address *Vandalia 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 this body is not embalmed, fact should be so stated above.