

FILED SEP 28 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **21408**

Registration District No. **209** Primary Registration District No. **3043** Registrar's No. **338**

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>Marion</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Hannibal</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Residence 3118 St. Charles</b> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <b>3118 St. Charles</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Corrie Withers Smarr</b> First Middle Last			4. DATE OF DEATH <b>September 13, 1956</b> Month Day Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Widowed</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 27, 1864</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>92</b> IF UNDER 1 YEAR Months <b>2</b> Days <b>16</b> IF UNDER 24 HRS. Hours <b>0</b> Min.
11. BIRTHPLACE (City and state or country) <b>Withers Mill Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Samuel Withers</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Sara Bradley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yrs. give year or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Harry Smarr, 3118 St. Charles Hannibal Mo.</b> Address		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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 <b>10:00 A</b> Month, Day, Year <b>9-10-56</b> a. m. p. m.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 <b>Hannibal Mo</b> COUNTY <b>Marion</b> STATE <b>Missouri</b>		20g. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>9-10-56</b> to <b>9-13-56</b> and last saw her alive on <b>9-13-56</b> Death occurred at <b>10:00 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
21a. SIGNATURE <b>[Signature]</b> (Type or print)		21b. ADDRESS <b>Hannibal Mo</b>	
21c. DATE SIGNED <b>Sept 17/56</b>		21d. ADDRESS	
23a. BURIAL, CREMATION, OR OTHER DISPOSAL <b>Providence Cemetery</b>		23b. DATE <b>Sept. 15, 1956</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Providence Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Marion County, Missouri</b>	
24. FUNERAL DIRECTOR <b>[Signature]</b> ADDRESS <b>Hannibal Mo</b>		25. DATE RECD. BY LOCAL REG. <b>9/18/1956</b>	
26. REGISTRAR'S SIGNATURE <b>[Signature]</b>		26. REGISTRAR'S SIGNATURE	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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RECEIVED \_\_\_\_\_  
MARION CO. HEALTH DEPT.  
DATE FILED \_\_\_\_\_

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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 *H Crawford Smith* \_\_\_\_\_

Licensed Embalmer No. .... 38

P. O. Address. Hannibal, Mis

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.