

Health, Welfare
Public
Service

300
1-56

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

FILED JAN 3 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42184

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 469

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>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Hannibal</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Levering Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>1209 Lyon St.</u>	
Length of stay in lb <u>92 yrs.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>MARY</u> Last <u>WILLIAMS</u>			4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>56</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28, 1863</u>	9. AGE (In years last birthday) <u>93</u>	10. IF UNDER 1 YEAR Months _____ Days _____ 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>Home</u>	11. BIRTHPLACE (City and state or country) <u>Germany</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Gottlieb Dreyer</u>			14. MOTHER'S MAIDEN NAME <u>Lucia Rosenbrook</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	17. INFORMANT <u>2900 Pleasant St. Mrs. E. L. Sparks, Hannibal, Mo.</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ch. Nephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>10 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arterio sclerosis</u>	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 _____ a. m. _____ p. m.	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION	COUNTY	STATE
21. I attended the deceased from <u>5-16-54</u> to <u>12-20-56</u> and last saw her <u>alive</u> on <u>12-20-56</u> Death occurred at <u>5:10 P.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>W. A. DeStefano, MD</u>	22b. ADDRESS <u>Hannibal, Mo.</u>	22c. DATE SIGNED <u>12-20-56</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE <u>12-22-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Pk.</u>
23d. LOCATION (City, town, or county) <u>Hannibal, Mo.</u>		(State)

24. FUNERAL DIRECTOR <u>Jack Schwartz</u>	ADDRESS <u>Hannibal, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec 28 - 1956</u>	26. REGISTRAR'S SIGNATURE <u>W. M. Luke By H. C. Fisher</u>
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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED JAN 2 1957
MARION, O. HEALTH DEPT.
DATE FILED JAN 2 1957

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 *Jack Stewart*.....
Licensed Embalmer No. *495*

P. O. Address *Hennils*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.