

Dr. Strong

THE DEPARTMENT OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

1959

FILED JAN 23 1957

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 24

1. PLACE OF DEATH a. COUNTY Marion				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Ralls				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Saverton		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Levering			Length of stay in 1b	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James C. Charlton				First	Middle	Last	4. DATE OF DEATH 1-15-57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/9/1881		9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lockman			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James S. Charlton				14. MOTHER'S MAIDEN NAME Mary Peeler Charlton				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 342-20-4779		17. INFORMANT Mrs. Minnie Estelle Charlton, Address Saverton, Mo.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct							INTERVAL BETWEEN ONSET AND DEATH 1 Day	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 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 checked="" type="checkbox"/> NO <input 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 <input type="checkbox"/> Month, Day, Year a. m. <input type="checkbox"/> p. m.								
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		COUNTY		STATE
21. I attended the deceased from Jan 14-57 to Jan 15-57 and last saw ^{her} him alive on Jan 14-57 Death occurred at 4:45 AM m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE F. E. Sultzman M.D. (Degree or title)				22b. ADDRESS 115 N Fifth Hannibal, Mo			22c. DATE SIGNED 1-16-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-18-57	23c. NAME OF CEMETERY OR CREMATORY Fox Creek Cemetery,		23d. LOCATION (City, town, or county) (State) Mozier, Illinois.			
24. FUNERAL DIRECTOR N. M. O'Donnell ADDRESS Hannibal, Mo.			25. DATE RECD. BY LOCAL REG. 1-18-57		26. REGISTRAR'S SIGNATURE Dr. Emb Lucke, By W. Fisher			

(Licensed Embalmer's Statement on Reverse Side)

Health,
Welfare
Public
Service300
1-56

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

MEDICAL CERTIFICATION

RECEIVED JAN 22 1957
MARION CO. HEALTH DEPT.
DATE FILED JAN 22 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..... *J. M. O'Donnell*

Licensed Embalmer No... 388

P. O. Address... Hannibal,

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.