

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

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 15 1957

STATE FILE NUMBER **5510**

Registration District No. **209** Primary Registration District No. **3043** Registrar's No. **87**

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 checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Hannibal</b>		0644 0 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Levering Hospital</b>		Length of stay in 1b	d. STREET ADDRESS <b>1002 Center</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GREGORY</b> Middle <b>DALE</b> Last <b>BELSHE</b>			4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 4, 1957</b>	9. AGE (In years last birthday) IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>XX</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>XX</b>	11. BIRTHPLACE (City and state or country) <b>Hannibal Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Dale Belshe</b>			14. MOTHER'S MAIDEN NAME <b>Shirley N. Frazier</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>XX</b> <b>XX</b>		16. SOCIAL SECURITY NO. <b>XX</b>	17. INFORMANT Address <b>Dale Belshe Hannibal Missouri</b>		
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>Defective &amp; Premortals</b> <b>Pneumothorax, Bilateral</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
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.) <b>1</b>		
20c. TIME OF INJURY Hour <b>7</b> Month <b>6</b> Day <b>20</b> Year <b>1957</b> a. m. <b>20</b> p. m.			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <b>Hannibal Missouri</b>		20g. COUNTY STATE	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at <b>1:00 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Samuel B. Jordan, M.D.</b> (Degree or title)			22b. ADDRESS		22c. DATE SIGNED <b>2-6-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/7/1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grand View Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Hannibal Missouri</b>	
24. FUNERAL DIRECTOR <b>W. Crawford Smith</b> Address <b>Hannibal Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>3-6-57</b>		26. REGISTRAR'S SIGNATURE <b>Dr. Em. Lucke</b>	

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED MAR 13 1957  
MARION CO. HEALTH DEPT.  
DATE FILED MAR 13 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 *John S. Ward*  
Licensed Embalmer No. 454

P. O. Address Hannibal, Mo.

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.