

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 MAR 4 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 5503

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 70

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) <b>Hannibal</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Hannibal</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>Levering Hospital</b>		Length of stay in lb <b>14 hours</b>		d. STREET ADDRESS <b>3504 Market Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JAMES THOMAS CROSS</b>				4. DATE OF DEATH <b>February 19, 1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 19, 1876</b>	
9. AGE (In years last birthday) <b>80</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boiler maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>St. Louis &amp; Hannibal</b>		11. BIRTHPLACE (City and state or country) <b>St. Joseph Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				13. FATHER'S NAME <b>James T. Cross</b>			
14. MOTHER'S MAIDEN NAME <b>Emma not known</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>			
16. SOCIAL SECURITY NO. <b>486 14 1570</b>				17. INFORMANT Address <b>Mrs. James T. Cross 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>Chr. myocarditis with decompensation</b>						INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <b>Severe secondary anemia</b>	
DUE TO (c) _____						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 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>293X</b>				
20c. TIME OF INJURY Hour <b>9:25 P</b> a. m. <b>2:25 P</b> 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 <b>Hannibal Mo</b>		COUNTY <b>Marion</b>		
20g. STATE <b>Missouri</b>		21. I attended the deceased from <b>2/19/57</b> to <b>2/19/57</b> and last saw <b>him</b> alive on <b>2/19/57</b> Death occurred at <b>9:25 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>[Signature]</b>				22b. ADDRESS <b>Hannibal Mo</b>		22c. DATE SIGNED <b>2/21/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/21/1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet</b>		23d. LOCATION (City, town, or county) (State) <b>Hannibal Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>[Signature] Hannibal Missouri</b>			25. DATE REC'D. BY LOCAL REG. <b>2-23-57</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED MAR 1 1957  
MARION CO. HEALTH DEPT.  
DATE FILED MAR 1 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.....  
*H. Crawford Smith*

Licensed Embalmer No. 3814.

P. O. Address Hannibal Miss

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.