

Dr. Strang

## STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 57-017919

FILED MAY 22 1957

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 184

Health,  
& Welfare  
Public  
ServiceS. 300  
y. 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

1. PLACE OF DEATH a. COUNTY <b>Marion</b>				2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE <b>Michigan</b> b. COUNTY <b>Wayne</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Hannibal</b> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Detroit</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>Levering</b>			Length of stay in lb	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Concetta</b> Middle <b>Bramblett</b> Last <b>Bramblett</b>				4. DATE OF DEATH Month <b>5</b> Day <b>8</b> Year <b>57</b>			
5. SEX <b>Female</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>6/15/1915</b>		9. AGE (In years last birthday) <b>41</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>28</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</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	11. BIRTHPLACE (City and state or country) <b>Alton, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Anthony Nicosia</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Cossetta</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Robert Bramblett, Detroit, Mich.</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>Alumina</b> DUE TO (b) <b>Carcinomatosis</b> DUE TO (c) <b>*Krukenberg tumor of Stomach</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <b>175X</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 mo</b>	
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>p. m.</b> Month <b>5</b> Day <b>8</b> Year <b>57</b>							
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 STATE	
21. I attended the deceased from <b>4-14-57</b> to <b>5-8-57</b> and last saw her/him alive on <b>5-8-57</b> Death occurred at <b>12:50 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>R M Strang MD</b> (Degree or title)				22b. ADDRESS <b>Hannibal, Mo.</b>		22c. DATE SIGNED <b>5-14-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/11/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grand View Burial Park</b>		23d. LOCATION (City, town, or county) <b>Hannibal, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>W M O'Donnell</b>			ADDRESS <b>Hannibal, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>5-14-57</b>	26. REGISTRAR'S SIGNATURE <b>Dr. E. M. Lucke By W. C. Fisher</b>		

(Licensed Embalmer's Statement on Reverse Side)

189

RECEIVED MAY 21 1957  
MARION CO. HEALTH DEPT.  
DATE FILED MAY 21 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. M. O'Connell* .....

Licensed Embalmer No. 3889

P. O. Address Hannibal, .....

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.