

Health,
& Welfare
Public
Service

3-300
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 NOV 1 1957

STANDARD CERTIFICATE OF DEATH

5766

36656

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. ~~3003~~ Registrar's No. 412

1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before death; or, if institution; Residence before death; or, if institution; Residence before death) a. STATE <u>Mo.</u> b. COUNTY <u>Marion</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <u>Miller Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Miller Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R.R.#3</u>			Length of stay in lb <u>Life</u>		d. STREET ADDRESS (If outside, give location) <u>R.R.#3</u>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Oscar</u> Last <u>Atkins</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>21</u> Year <u>1957</u>				
5. SEX <u>MALE</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>October 26, 1862</u>		9. AGE (In years last birthday) <u>95</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Miller Township-Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Atkins</u>				14. MOTHER'S MAIDEN NAME <u>Sophia SCHULTZ CHRISTIAN</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year and dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>J. Oney Atkins R.R.#3</u>			Address
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>Arteriosclerosis, cerebral</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized atherosclerosis</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. Month, Day, Year _____								
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 <u>1-9-55</u> to <u>10-21-57</u> and last saw her <u>alive</u> on <u>Oct 1, 1957</u> Death occurred at <u>2 am</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>Hannibal Mo</u>			22c. DATE SIGNED <u>10-22-57</u>	
23a. BURIAL, CREMATION, etc. (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
<u>Burial</u>		<u>10-23-57</u>		<u>Mt. Olivet Cemetery</u>		<u>Hannibal, Mo.</u>		
24. FUNERAL DIRECTOR <u>Jack Schwortz - Hannibal, Mo.</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>10-23-57</u>		26. REGISTRAR'S SIGNATURE <u>No. Em. Luck. By W.C. Fisher</u>

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED OCT 30 1957
MARION CO. HEALTH DEPT.
DATE FILED OCT 30 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.....

Licensed Embalmer No. 490

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.