

FILED DEC 12 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41816

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 469

1. PLACE OF DEATH a. COUNTY <u>Marion</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Shelby</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Shelbyville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Elizabeth Hospital</u>			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>102<sup>o</sup></u>
3. NAME OF DECEASED (Type or print) First <u>ETTA</u> Middle <u>PEARL</u> Last <u>DAMBELL</u>			4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 27, 1880</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Month <u>11</u> Days <u>29</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Shelby County Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>AARON FOREMAN</u>			14. MOTHER'S MAIDEN NAME <u>MARTHA VIRGINIA COPENHAVER</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS. MATTIE SANDERS, SHELBYVILLE MISSOURI</u>	
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>Pneumonia &amp; Uremia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <u>Congestive Heart Failure</u>					<u>2 years</u>
DUE TO (c) <u>Hypertensive Heart Disease</u>					<u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443X</u> <u>Aortic Aneurysm and Aortic Insufficiency</u>					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.) <u></u>			
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>					
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>10-16-55</u> to <u>11-26-57</u> and last saw <sup>her</sup> / <sub>him</sub> alive on <u>11-26-57</u> Death occurred at <u>11:50 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>E. L. Lucas</u> (Degree or title)			22b. ADDRESS <u>M.D. 100 N. Sixth, Hannibal, Mo.</u>		22c. DATE SIGNED <u>11-29-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11/29/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>T O O F Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Shelbyville Missouri</u>
24. FUNERAL DIRECTOR <u>W. Crawford</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>11-30-57</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke W. C. Tucker</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health,  
Welfare  
Public  
Service300  
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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

ascertain the medical certification in this specific manner required by 193.140 MOCS 1987.

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RECEIVED

MARION CO. HEALTH DEPT.

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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. ....7814

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.