

FILED APR 3 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-010692
STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 99

300
1-57

4

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal Missouri</u>		c. CITY OR TOWN <u>Hannibal</u>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Becky Thatcher Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>1101 Center</u>	
3. NAME OF DECEASED (Type or print) First <u>KARL</u> Middle <u>C</u> Last <u>BOSTWICK</u>		4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1958</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>June 21, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		11. BIRTHPLACE (City and state or country) <u>Cameron Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>George H. Bostwick</u>		14. NAME OF HUSBAND OR WIFE <u>Geneva Fielder Bostwick (dec)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u>		17. INFORMANT <u>Chester Bostwick Mundelein Illinois</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>Cerebral atherosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>atherosclerosis general</u> DUE TO (c) <u>Parkinsonism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>1 yr</u> <u>5 years</u>	
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 <u>1:30 A.</u> Month, Day, Year		20f. CITY, TOWN, OR LOCATION <u>Hannibal</u> COUNTY <u>Mo</u> STATE <u>Mo</u>	
21. I attended the deceased from <u>1936</u> to <u>March 23, 1958</u> and last saw him alive on <u>March 22, 1958</u> Death occurred at <u>1:30 A.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <u>Just as clergy M.D.</u> (Degree or title)		22b. ADDRESS <u>Hannibal Mo</u>	
22c. DATE SIGNED <u>3-25-58</u>		23. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/25/58</u>	
24. FUNERAL DIRECTOR <u>W. Crawford Smith, Hannibal Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>3-29-58</u>	
26. REGISTRAR'S SIGNATURE <u>D. E. M. Lucie</u>		27. REGISTRAR'S SIGNATURE <u>W. C. Fisher</u>	

RECEIVED APR 3 1958
MARION CO. HEALTH DEPT.,
DATE FILED APR 3 1958

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. 214

P. O. Address Hannibal, Missouri

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.