

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037108  
STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 326

1. PLACE OF DEATH a. COUNTY <u>Missouri Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Rolls</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>Hannibal</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>Levering Hospital</u>		Length of stay in lb <u>DOA</u>		d. STREET ADDRESS (If outside, give location) <u>2022 Orchard Avenue</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK</u> <u>H. CL</u> <u>DARR</u>				4. DATE OF DEATH Month Day Year <u>October 4, 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 1, 1882</u>		9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life) even if retired <u>Retired Car Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C.B. &amp; Q.R.R.</u>		11. BIRTHPLACE (City and state or country) <u>Chillicothe Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13a. FATHER'S NAME <u>Hiram Darr</u>			13b. MOTHER'S MAIDEN NAME <u>Matelia Not known</u>			14. NAME OF HUSBAND OR WIFE <u>Zella Geist Darr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>499 05 7514 A</u>		17. INFORMANT Address <u>Mrs. H.F. Darr, Hannibal 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>Myocardial infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arterio-sclerotic heart disease</u>						8 years	
DUE TO (c) <u>4200</u>							
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 Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>10/4/58</u> to <u>10/4/58</u> and last saw her alive on <u>10/4/58</u> Death occurred at <u>8:00 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>J. S. Waterscheid M. D.</u>				22b. ADDRESS <u>508 Broadway, Hannibal, Mo.</u>		22c. DATE SIGNED <u>10/6/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/7/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>		
24. FUNERAL DIRECTOR <u>Crawford Smith, Hannibal Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>10-9-58</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke</u>	

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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

RECEIVED OCT 17 1958  
MARION CO. HEALTH DEPT.  
DATE FILED OCT 17 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 *John S. Stand* .....

Licensed Embalmer No. .... 1540 .....

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.