

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022166  
STATE FILE NUMBER

FILED JUL 8 1959 Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 188

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Marion</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Marion</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Hannibal</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Hannibal</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Clarks Rest Home</b>		Length of stay in lb <b>8 Mo.</b>	STREET ADDRESS (If outside, give location) <b>408 Rock St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Christopher Constable</b>			4. DATE OF DEATH Month Day Year <b>June 16. 1959</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 10, 1874</b>	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <b>85</b> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gov. Air Base</b>	11. BIRTHPLACE (City and state or country) <b>Hannibal, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Issac Constable</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Cain</b>		14. NAME OF HUSBAND OR WIFE <b>Ellen Constable</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. <b>285-22-0360A</b>		17. INFORMANT Address <b>Mrs. Ethel Copenhaver 1000 Ely. St</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>CA Urinary Bladder with Metastasis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>181C</b>					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 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 <b>5-11-59</b> to <b>June 4, 1959</b> and last saw him <b>alive</b> on <b>June 4, 1959</b> Death occurred at <b>3:00 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Doctor or Informant) <i>[Signature]</i>			22b. ADDRESS <i>[Signature]</i>		22c. DATE SIGNED <b>7-1-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 18, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grandview Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hannibal, Missouri</b>
24. FUNERAL DIRECTOR <i>[Signature]</i>		ADDRESS <b>1000 BdW.</b>		25. DATE RECD. BY LOCAL REG. <b>7-2-59</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

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 *Jack Schwartz* .....

Licensed Embalmer No. *4900* .....

P. O. Address *Hospital* .....

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.