

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029806

FILED VS AUG 26 1959

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 250 STATE FILE NUMBER

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) OR TOWN <b>Hannibal</b>		Length of stay in lb		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>St. Elizabeth Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>212 North Eighth</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>WING</b> Last <b>WING</b>				4. DATE OF DEATH Month <b>August</b> Day <b>20</b> Year <b>1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>5/18/1892</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>2</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Illinois State Highway</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Highway</b>		11. BIRTHPLACE (City and state or country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Truman Wing</b>			13b. MOTHER'S MAIDEN NAME <b>Not known</b>			14. NAME OF HUSBAND OR WIFE		
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>498 01 5829</b>		17. INFORMANT <b>Mrs Robert Ruff Quincy Illinois</b> 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) <b>Hepatic coma</b> DUE TO (b) <b>Congestive heart failure</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 <b></b> Month, Day, Year <b></b> a.m. <b></b> p.m. <b></b>								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>8/7/59</b> to <b>8/20/59</b> and last saw her him alive on <b>8/20/59</b> Death occurred at <b>3:00 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>J. H. Hattis M.D.</b>				22b. ADDRESS <b>508 Broadway, Hannibal, Mo.</b>			22c. DATE SIGNED <b>8/21/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8/22/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>South Side Cemetery</b>		23d. LOCATION (City, town, or county) <b>Clayton Illinois</b>		(State)	
24. FUNERAL DIRECTOR <b>W. Crawford Smith Hannibal Missouri</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>8/21/59</b>		26. REGISTRAR'S SIGNATURE <b>St. M. Lucke By J. C. Fisher</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John S. Mend

Licensed Embalmer No. 4540

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.