

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-030102
STATE FILE NUMBER

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 278
FILED AUG 17 1961

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| 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</u> | | Length of stay in 1b | c. CITY OR TOWN <u>Hannibal</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Levering Hospital</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>715 A Center</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>FERN</u> Middle <u>MOLITOR</u> Last <u>RIPLEY</u> | | | 4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1961</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 5, 1898</u> | 9. AGE (last birthday) <u>62</u> | IF UNDER 1 YEAR Months <u>9</u> Days <u>3</u> Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>American Year Book</u> | 11. BIRTHPLACE (City and state or country) <u>Sauk Centre Minnesota</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U S A</u> |
| 13a. FATHER'S NAME <u>Joe Molitor</u> | | 13b. MOTHER'S MAIDEN NAME <u>Myra (Not known)</u> | | 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) <u>No</u> | | | 17. INFORMANT <u>Self Record</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>Leukemia</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Abdominal Carcinomatous</u> | | | | | <u>6 mos.</u> |
| DUE TO (c) <u>Carcinoma of ovary</u> | | | | | <u>1 yr</u> |
| 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 checked="" 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 <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>4-26-58</u> to <u>8-8-61</u> and last saw her ^{her} _{him} alive on <u>8-7-61</u> Death occurred at <u>1:40 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (If degree or title) <u>Frank R. Bureau M.D.</u> | | | 22b. ADDRESS <u>Hannibal, Missouri</u> | | 22c. DATE SIGNED <u>8-8-61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>8/10/1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Sauk Centre Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Sauk Centre Minnesota</u> | |
| 24. FUNERAL DIRECTOR <u>W. Crawford Smith Hannibal Missouri</u> | | | 25. DATE RECD. BY LOCAL REG. <u>8-10-1961</u> | | 26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lewis & Lillian M. Herman</u> |

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 W Crawford Smith
Licensed Embalmer No. 3814

P. O. Address Hennibel 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.