

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037734
STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 357

FILED OCT 31 1961

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Marion	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal		Length of stay in 1b 2 days	c. CITY OR TOWN Hannibal Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Levering Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2034 Broadway Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First William Middle Schwanke Last Schwanke	4. DATE OF DEATH Month 10 - Day 11 - Year 1961
---	--

5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-22-86	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months 7 Days 4	IF UNDER 24 HR Hours 4 Min. 0
--------------------	-------------------------------	---	----------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (City and state or country) Nebraska	12. CITIZEN OF WHAT COUNTRY USA
---	--	---	---

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Nettie Schwanke
--------------------------------------	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT Address Nettie Schwanke - Hannibal, Mo.
---	-------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, severe		INTERVAL BETWEEN ONSET AND DEATH 3 days
DUE TO (b) Diabetis mellitus, severe		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Severe arteriosclerotic vascular		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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 5:40P Month, Day, Year 10-9-61	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 Hannibal, Mo.	COUNTY Marion	STATE Mo.
--	---	--	--	-------------------------	---------------------

21. I attended the deceased from **10-9-61** to **10-11-61** and last saw **him** alive on **10-11-61**
Death occurred at **5:40P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Robert Lanning MD</i> (D, free or title)	22b. ADDRESS 115 North Fifth St. Hannibal, Mo.	22c. DATE SIGNED 10-19-61
---	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-14-1961	23c. NAME OF CEMETERY OR CREMATORY Grand View Cemetery	23d. LOCATION (City, town, or county) (State) Hannibal, Mo.
--	--------------------------------	--	---

24. FUNERAL DIRECTOR Clark Funeral Home - Hannibal, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 10/21/61	26. REGISTRAR'S SIGNATURE <i>Dr. E. M. Luche by William M. Sherman</i>
---	---------	---	---

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 4217

P. O. Address Hannibal, Mo.

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.