

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041753

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 394 STATE FILE NUMBER

1. PLACE OF DEATH
 a. COUNTY Marion
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal Length of stay in 1b _____
 c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 917 Georgia St. Inside Limits Yes No
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Mo b. COUNTY Marion
 c. CITY OR TOWN Hannibal Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 917 Georgia St. Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Sarah Middle E. Last Waldschlager
4. DATE OF DEATH Month Nov Day 9 Year 1961
5. SEX F **6. COLOR OR RACE** W
7. Married **Never Married**
Widowed **Divorced**
8. DATE OF BIRTH Dec 23 1877 **9. AGE (last birthday)** 83
 IF UNDER 1 YEAR IF UNDER 24 HR
 Months 10 Days 16 Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (City and state or country) Galhoun Cy Ill
12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Samuel Curtis
13b. MOTHER'S MAIDEN NAME Rhoda Unknown
14. NAME OF HUSBAND OR WIFE John F. Waldschlager
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 Fred Waldschlager Address 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) General debilitation
 DUE TO (b) CVA
 DUE TO (c) arterio sclerosis (gened)
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
 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.
 Yes No Unknown
INTERVAL BETWEEN ONSET AND DEATH Immediate

19. WAS AUTOPSY PERFORMED? YES NO
20a. ACCIDENT **SUICIDE** **HOMICIDE**
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
20d. INJURY OCCURRED WHILE AT WORK **NOT WHILE AT WORK**
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 on 11/9/61 to _____ and last saw her/him alive on _____
 Death occurred at _____ 2:30PM on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE [Signature] (Degree or title) _____
22b. ADDRESS _____
22c. DATE SIGNED _____

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Nov 11 1961
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery
23d. LOCATION (City, town, or county) (State) Hannibal Missouri
24. FUNERAL DIRECTOR Smith's Funeral Home ADDRESS Hannibal Mo
25. DATE RECD. BY LOCAL REG. Nov. 14, 1961
26. REGISTRAR'S SIGNATURE [Signature]

FISHER (Licensed Embalmer's Statement on Reverse Side) M. Norman

DATE AMENDED
 INSTEAD OF
 SHOULD READ
 ITEM NO.

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

John S. Staul

Licensed Embalmer No.

4540

P. O. Address

Hannover

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.