

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-045564

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 447

STATE FILE NUMBER

AMENDED

FILED JAN 9 1962

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal		c. CITY OR TOWN Hannibal	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Elizabeth Hospital		d. STREET ADDRESS (If outside, give location) 3233 St. Charles	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MARTHA Middle V Last FARRIS			4. DATE OF DEATH Month December Day 19 Year 1961		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1891	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months 11 Days 18	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant	10b. KIND OF BUSINESS OR INDUSTRY Long's Rest Home	11. BIRTHPLACE (City and state or country) Memphis Missouri	12. CITIZEN OF WHAT COUNTRY U S A
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13a. FATHER'S NAME James H. Vaught	13b. MOTHER'S MAIDEN NAME Mary Elizabeth Pence	14. NAME OF HUSBAND OR WIFE Mrs. J. W. Youle Winthrop Harbor Illinois
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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 Mrs. J. W. Youle Winthrop Harbor Illinois
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage		2 yrs.
DUE TO (b) Essential Hypertension		2 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (c)		

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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

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 Hannibal	COUNTY Marion	STATE Missouri
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21. I attended the deceased from **12-20-59**, to **12-19-61** and last saw her **alive** on **12-19-61**
Death occurred at **1:45 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>W. Crawford Smith</i>	(Degree or title) M.D.	22b. ADDRESS 100 N. Sixth, Hannibal, Mo.	22c. DATE SIGNED 12-20-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/22/1961	23c. NAME OF CEMETERY OR CREMATORY Grand View Burial Park	23d. LOCATION (City, town, or county) Hannibal Missouri
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24. FUNERAL DIRECTOR W. Crawford Smith, Hannibal Missouri	ADDRESS	25. DATE RECD. BY LOCAL REG. Dec. 20, 1961	26. REGISTRAR'S SIGNATURE <i>E. M. Lucke by William M. Herman</i>
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DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

DOCUMENT

ITEM NO. SHOULD READ

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 A. Ward
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.