

29010

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 508

Primary Registration District No. 3026

Registrar's No. 108

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) 2

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) Life

3. (a) PRINT FULL NAME Cathrine B. M^{rs} Carmick

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John M^{rs} Carmick

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Oct. 15 - 1873
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>67</u>	<u>0</u>	<u>7</u>	hr. _____ min. _____

9. Birthplace Londani, Ohio
(City, town or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name Andrew Cusick

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Catherine Donahue

15. Birthplace Ireland
(City, town or county) (State or foreign country)

16. (a) Informant's own signature John M^{rs} Carmick

(b) Address Wheat, Michigan

17. (a) Burial (b) Date thereof Aug 22 - '40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chillicothe, Mo.

18. (a) Signature of funeral director James Doulon

(b) Address Chillicothe, Mo.

19. (a) Aug 24 - '40 (b) J. M. Groves M. D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn

(c) City or town Chillicothe
(If outside city or town limits, write "RURAL")

(d) Street No. 415 Raymond
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 20 year 1940 hour 9 minute 30 A. M.

21. I hereby certify that I attended the deceased from June 1, 1938, to Aug 20, 1940, that I last saw her alive on June 15, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Regurgitation Duration 5 years

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 943
While at work? _____ (Specify type of place) Means of injury _____

23. Signature A. Calver (M. D. certificate) _____

Address Chillicothe, Mo. Date signed 8/24/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 11,

District File Number 740-143

Date Filed 5-1-1920

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.....

Donald Z. Gordon....., Registered Apprentice No. 223
working under my personal supervision.

Signed James D. Gordon
Licensed Embalmer No. 1870
P. O. Address Chillicothe 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 this body is not embalmed, above space should be left blank.