

FILED APR 15 1944

Registration District No. 67

Primary Registration District No. 6260

Registrar's No. 57

1. PLACE OF DEATH:

(a) County Christian  
(b) City or town Chadwick Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Chadwick  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community most of her life  
years, months or days)

3. (a) PRINT FULL NAME Catharine Otis Falmon

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married 2 divorced, widowed  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Nov 25 1862  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
81 4 10 hr. \_\_\_\_\_ min.

9. Birthplace mt Pleasant Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Wm Water  
13. Birthplace unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Nancy Jane Tague  
15. Birthplace mt Pleasant Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant Jesse H. Freeman  
(b) Address Chadwick Mo

17. (a) Burial (b) Date thereof April 7, 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chadwick

18. (a) Signature of funeral director J. B. Chappin

(b) Address Chadwick Mo

19. (a) 4-13-1944 (b) Mrs S. M. Johnson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Christian 22  
(c) City or town Chadwick Mo 0  
(If outside city or town limits, write "RURAL") 5  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.  
Immediate cause of death Heart attack ✓

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy None

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?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 05

23. Signature M. B. Logan acting coroner  
Address Osage Mo 4/17 Date signed 1944

**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.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed T. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Ozark 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, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
67  
Registrar's No. 67

Registration District No. 67

Primary Registration District No. 5260

1. PLACE OF DEATH:

(a) County Christian  
(b) City or town Chadwick  
(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)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Catherin Steu Treman

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov - 20 1886  
(Month) (Day) (Year)

8. AGE: Years 81 Months 4 Days \_\_\_\_\_ (If less than one day, \_\_\_\_\_ min.)

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Taura

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 14 Year 1944 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Heart attack  
chronic

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

23. Signature M. P. Logan Acting Coroner (M. D. or other)

Address 4117 - 44 Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

10677