

FILED NOV 8 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 324

Primary Registration District No. 372

Registrar's No. 153

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
356 West Arrow
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community All His Life
years, months or days)

3. (a) PRINT
FULL NAME

Henry S. Caton

3. (b) If veteran,
name war # _____

3. (c) Social Security
No. # _____

4. Sex Male 0
5. Color or
race White

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

6. (b) Name of husband or wife
Evangeline Oneal

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

7. Birth date of deceased August 17
(Month) (Day) (Year)

1862
(Month) (Day) (Year)

8. AGE:

83 Years

2 Months

- Days

If less than one day

_____ hr. _____ min.

9. Birthplace Otterville
(City, town, or county)

Mo.
(State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Aaron Caton

13. Birthplace Unknown
(City, town, or county)

Unknown
(State or foreign country)

14. Maiden name Evangeline Oneal

15. Birthplace Unknown
(City, town, or county)

Unknown
(State or foreign country)

16. (a) Informant Mrs. H.E. Hilton

(b) Address Marshall, Mo.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 10/19/1945
(Month) (Day) (Year)

(c) Place: burial or cremation Arrow Rock, Mo.

18. (a) Signature of funeral director [Signature]

(b) Address Marshall, Mo.

19. (a) 10-19-45
(Date received local registrar)

(b) _____
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline
(c) City or town Marshall
(If outside city or town limits, write "RURAL")
(d) Street No. 356 West Arrow
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 17
year 1945 hour 7 P.M. minute ✓ M.

21. I hereby certify that I attended the deceased from Jan
1935 to Oct 17 1945
that I last saw him alive on Oct 16 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis
Duration 24y

Due to _____
Due to _____

Other conditions Blind
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____
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?

(Specify type of place)
While at work _____ (e) Means of injury _____
23. Signature [Signature] (M. D. or other)
Address Marshall, Mo. Date signed 10/19/45

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

RECEIVED

District Health Officer No. _____

District File Number _____

Date Filed 11-8-43

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 _____

Licensed Embalmer No. 3235

P. O. Address Marshall, Va.

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.

STANDARD CERTIFICATE OF DEATH

State File No.

Nov

Registrar's No.

153

Registration District No.

324

Primary Registration District No.

3072

1. PLACE OF DEATH:

- (a) County Saline
(b) City or town Marshall
(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 years, months or days)

3. (a) PRINT FULL NAME

Henry S. Caten

3. (b) If veteran,
name war

3. (c) Social Security
No.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married,
divorced wid
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if
alive 1867 years
7. Birth date of deceased Aug 11 1867

8. AGE: Years 83 Months 2 Days mo (less than one day) min.

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

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 10-19-45 (b) Mrs F. D. Westbrook
(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 Oct day 17 year 1945 hour 10 minute 15 M.
21. I hereby certify that I attended the deceased from 10/17/45 to 10/17/45, 1945;
that I last saw him alive on 10/17/45, 1945;
and that death occurred on the date and hour stated above.
Immediate cause of death

- Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy
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

23. Signature (M. D. or other) Address Date signed

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

SUPPLEMENTARY

347600