

No. 2
2-45
17-39
K47070

FILED AUG 8 1947

Registration District No. **5593**

Primary Registration District No. **5593**

Registrar's No. **459**

1. PLACE OF DEATH:

(a) County Jefferson
(b) City or town Rural Platin
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson
(c) City or town R.F.D.1 Festus
(If outside city or town limits, write "RURAL")
(d) Street No. 10 Miles south of Festus
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Delbert D. Cather

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frances Cather 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Sept. 18 1868
(Month) (Day) (Year)

8. AGE:			If less than one day
Years	Months	Days	
<u>78</u>	<u>9</u>	<u>27</u>	hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Jamess Cather

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

14. Maiden name _____

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

16. (a) Informant Frances Cather

(b) Address Festus, R.F.D.1

17. (a) Burial (b) Date thereof 7-17-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Methodist Cemetery

18. (a) Signature of funeral director Fink Funeral Parl

(b) Address Festus, Mo

19. (a) July 28 47 (b) Wanda B. Thompson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15 year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from July 15 1947 to _____ 1947
that I last saw him alive on July 15 and that death occurred on the 15 day and hour stated above.

Immediate cause of death Chronic myo carditis

Due to _____

Due to _____

Other conditions: Hypertension
(Include pregnancy within _____ months of death)

Major findings: 97P
Of operations: _____
Of autopsy: _____

Duration _____
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? _____

Which at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Donald Brejars (M. D. or other) _____
Address Festus Mo Date signed 7/20/47

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

MOTHER FATHER

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. 498
working under my personal supervision.

Signed *Elena Province*

Licensed Embalmer No. 3403

P. O. Address *Festus M*

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.

Registration District No. 248 Primary Registration District No. 5593

1. PLACE OF DEATH:

(a) County Jefferson
 (b) City or town Quail
(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 years, months or days)

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 _____

3. (a) PRINT FULL NAME Delbert D. Cather

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 M

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

7. Birth date of deceased Sept 18
(Month) (Day) (Year)

8. AGE: 78 Years 10 Months 10 Days 10 hr. 10 min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____
13. Birthplace Mo
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) 8/15/47 (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 8/15/47 (b) Marie Harris
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

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) (e) Means of injury _____

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

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

24612