

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **24531**

FILED JUL 21 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **137** PRIMARY REG. DIST. NO. **3023** Registrar's No. **164**

04220

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

|   |                               |  |  |  |   |
|---|-------------------------------|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Henry</b>   |                               |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Mo</b> b. COUNTY <b>Henry</b> |  |   |
| b. CITY (If outside corporate limits write RURAL and give township) OR TOWN <b>Clinton</b>  |                               | c. LENGTH OF STAY (In this place) <b>today</b>   | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Montrose</b>                                       |  | D 420   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Clinton General Hosp.</b>  |                               |  | d. STREET ADDRESS (If rural, give location) <b>none</b>  |  |   |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>JAMES</b> b. (Middle) <b>Noah</b> c. (Last) <b>CATON</b>   |                               |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>July 16 1953</b>   |  |   |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>   | 8. DATE OF BIRTH <b>Nov 15 1887</b>  |  | 9. AGE (In years last birthday) <b>76</b>                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stockman</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>   | 11. BIRTHPLACE (City and State or Foreign Country) <b>Johnson City Mo</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                               |
| 13a. FATHER'S NAME <b>Jasper Caton</b>  |                               | 13b. MOTHER'S MAIDEN NAME <b>Margie Newell</b>   | 14. NAME OF HUSBAND OR WIFE <b>Unknown</b>   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>  |                               | 16. SOCIAL SECURITY NO. <b>None</b>  | 17. INFORMANT'S SIGNATURE OR NAME <b>Bessie E Swain</b> ADDRESS <b>Marion Ind</b>  |  |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.                                 |                               | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Congestive heart failure</b><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>arterio-sclerotic heart disease</b><br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b><br><br><b>Unknown</b> |
| 19a. DATE OF OPERATION <b>None</b>  |                               | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>No</b>  |                               | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)  |  |   |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>None</b>   |                               | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21f. HOW DID INJURY OCCUR?   |  |   |
| 22. I hereby certify that I attended the deceased from <b>July 10 1953</b> , to <b>July 16 1953</b> , that I last saw the deceased alive on <b>July 16 1953</b> , and that death occurred at <b>7:45 P.M.</b> , from the causes and on the date stated above. |                               |  |  |  |   |
| 23a. SIGNATURE <b>S. R. Wiggins</b> (Degree or title) <b>M.D.</b>   |                               |  | 23b. ADDRESS <b>Clinton, Mo.</b>   |  | 23c. DATE SIGNED <b>7/17/53</b>                                       |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 24b. DATE <b>July 18</b>   | 24c. NAME OF CEMETERY OR CREMATORY <b>Appleton City</b>  | 24d. LOCATION (City, town, or county) (State) <b>Appleton City Mo</b>            |   |
| DATE REC'D BY LOCAL REG. <b>July 18 1953</b>  |                               | REGISTRAR'S SIGNATURE <b>Florence Adams</b>  |  | FUNERAL DIRECTOR'S SIGNATURE <b>D. Dunnington</b> ADDRESS <b>none</b>            |   |

**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 .....

Student Embalmer

Signed

*Robert L. Dunning*

Licensed Embalmer No. *4210*

P. O. Address *Clinton MS*

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.