S. No. 300
EV. 10.48

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FILED NOV 9 - 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35166
State File No.

BIRTH NO. REG. DIST. NO. 44 PRIMARY REG. DIST. NO. 4060 Registrar's No. 38

1. PLACE OF DEATH
a. COUNTY Caldwell
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Breckenridge
c. LENGTH OF STAY (In this place) 41 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Caldwell
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Breckenridge 0130 0
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Joe
b. (Middle) Arland
c. (Last) Catron

4. DATE OF DEATH (Month) (Day) (Year) Oct. 30 - 1953

5. SEX Male 0
6. COLOR OR RACE wh
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 6-28-1900
9. AGE (In years last birthday) 53 yrs | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam fitter
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME R.W. Catron
13b. MOTHER'S MAIDEN NAME Mary E. Catron
14. NAME OF HUSBAND OR WIFE Carea Catron

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 493-22-7990
17. INFORMANT'S SIGNATURE OR NAME Mrs Carea Catron
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) FIBRO Sarcoma of HIP — INTERVAL BETWEEN ONSET AND DEATH 15 MO.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 197X
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) Breckenridge (COUNTY) Caldwell (STATE) Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 14, 1953, *to* Oct 30, 1953, *that I last saw the deceased alive on* Oct 20, 1953, *and that death occurred at* 6A m., *from the causes and on the date stated above.*

23a. SIGNATURE Frank R. Dolert (Degree or title) M.D.
23b. ADDRESS Hamilton Mo.
23c. DATE SIGNED 10/31/53

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 1-1953
24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem
24d. LOCATION (City, town, or county) Breckenridge Mo. (State)

DATE REC'D BY LOCAL REG. 11-3-53
REGISTRAR'S SIGNATURE Mrs. Nell B. Jones 373-0
25. FUNERAL DIRECTOR'S SIGNATURE Breckenridge Funeral Home
ADDRESS Breckenridge Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

NOV 13 1989

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 Bernard F. Mead

Licensed Embalmer No. 2801

P. O. Address Braymer, 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.