

FILED NOV 29 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36592

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1221

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|-----------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Buchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph | | c. CITY OR TOWN St. Joseph | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) 26 Yrs | | e. STREET ADDRESS (If rural, give location) 3011 Penn St. | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital | | | |

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|-------------------------------------|-----------------|---------------------|------------------------------|-----------------------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Carl | b. (Middle) Ketchum | c. (Last) Ketchum | 4. DATE OF DEATH (Month) (Day) (Year) Nov. 24, 1954 |
|-------------------------------------|-----------------|---------------------|------------------------------|-----------------------------------------------------|

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|-------------|------------------------|----------------------------------------------------------------|-------------------------------|------------------------------------|-----------------------|---------------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Oct. 2, 1889 | 9. AGE (In years last birthday) 65 | # UNDER 1 YEAR Months | # UNDER 4 HRS. Hours Min. |
|-------------|------------------------|----------------------------------------------------------------|-------------------------------|------------------------------------|-----------------------|---------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. (2) Detective | 10b. KIND OF BUSINESS OR INDUSTRY City Police | 11. BIRTHPLACE (City and State or Foreign Country) Union Star, Mo. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME Jacob Ketchum Ketchum | 13b. MOTHER'S MAIDEN NAME Rhoda Moore | 14. NAME OF HUSBAND OR WIFE Lillian Ketchum |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give city and dates of service) Yes W.W.# 1 | 16. SOCIAL SECURITY NO. none | 17. INFORMANT'S SIGNATURE OR NAME Mrs Carl Ketchum | ADDRESS 3011 Penn St. |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury or complication which caused death.</i> | MEDICAL CERTIFICATION. St. Joseph, Mo. | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Heart Disease | | 1 yr 2 mo. |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pulmonary Emphysema DUE TO (c) Chronic Bronchitis | | 1 yr 2 mo. 4 yrs |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 21a. ACCIDENT (Specify) SUICIDE HOMICIDE | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
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| | | |
|-------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 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 7-25-53, 19____, to 11-24-54, 19____, that I last saw the deceased alive on 11-24-54, 19____, and that death occurred at 9:10a m., from the causes and on the date stated above.

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|----------------------------------------------------------|--------------------------------------|---------------------------|
| 23a. SIGNATURE <i>H. C. Allison MD</i> (Degree or title) | 23b. ADDRESS 207 PWS Bldg. St Joseph | 23c. DATE SIGNED 11-24-54 |
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|--------------------------------------------------|-------------------------|-----------------------------------------------|---------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Nov. 27, 1954 | 24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet | 24d. LOCATION (City, town, or county) (State) St. Joseph, Mo. |
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| DATE REC'D BY LOCAL REG. Nov 24, 1954 | REGISTRAR'S SIGNATURE <i>Kathleen M. Allison</i> 485 | 25. FUNERAL DIRECTOR'S SIGNATURE <i>Herman W. Sidenfaden</i> ADDRESS St Joseph, Mo |
|---------------------------------------|------------------------------------------------------|------------------------------------------------------------------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

M. C. Allison MD
St. Joseph, Mo.

DEC 3 1954

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.....
Signature of Student Embalmer

Signed.....
Robert R. Gayer

Licensed Embalmer No. 3308

P. O. Address St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.