No. 300
10.48

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

FILED DEC 14 1954

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 37951

BIRTH NO. 71178-54 REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 9040 Registrar's No. 10

**1. PLACE OF DEATH**
a. COUNTY: Livingston
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chillicothe
c. LENGTH OF STAY (In this place): 24 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Chillicothe Municipal Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Livingston
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chillicothe - Rural - Rich Hill
d. STREET ADDRESS (If rural, give location): R#5 - 4 mi. S.W. Chula, Mo

**3. NAME OF DECEASED** (Type or Print)
a. (First): Sally
b. (Middle): Ann
c. (Last): Childers

**4. DATE OF DEATH** (Month) Dec (Day) 4 (Year) 1954

**5. SEX**: Female
**6. COLOR OR RACE**: White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Never Married
**8. DATE OF BIRTH**: Jan 29 1954
**9. AGE** (In years last birthday): 0 — If under 1 year: Months 10, Days 5 — If under 24 hrs.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Child
**10b. KIND OF BUSINESS OR INDUSTRY**: ✓
**11. BIRTHPLACE** (State or foreign country): Chillicothe R#5 Missouri
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13a. FATHER'S NAME**: Clarence Childers
**13b. MOTHER'S MAIDEN NAME**: Sarah Thompson
**14. NAME OF HUSBAND OR WIFE**: None

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No
(If yes, give war or dates of service): ✓
**16. SOCIAL SECURITY NO.**: None
**17. INFORMANT'S SIGNATURE OR NAME**: Clarence Childers — **ADDRESS**: Chillicothe, Mo

**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.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, Bronchial, Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 4 days

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.* Spastic Paralysis — 11 Mos

**19a. DATE OF OPERATION**
**19b. MAJOR FINDINGS OF OPERATION**
491 X
**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) (COUNTY) (STATE)

**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* Jan 29, 1954, *to* Dec. 4, 1954, *that I last saw the deceased alive on* Dec. 4, 1954, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): Joseph A. Conrad M.D.
**23b. ADDRESS**: Chillicothe, Mo
**23c. DATE SIGNED**: Dec. 6-54

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**24b. DATE**: 12/6/1954
**24c. NAME OF CEMETERY OR CREMATORY**: Rickett Cemetery
**24d. LOCATION** (City, town, or county) (State): Chula Mo

**DATE REC'D BY LOCAL REG.**: Dec/6/54
**REGISTRAR'S SIGNATURE**: Frances B Neill
**25. FUNERAL DIRECTOR'S SIGNATURE**: F. J. Robertson Funeral Home — **ADDRESS**: Chula Mo

(Licensed Embalmer's Statement on Reverse Side)

## 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 J M Robertson

Licensed Embalmer No. 4388

P. O. Address Laredo 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.