

FILED JUN 27 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20836

BIRTH NO. _____		REG. DIST. NO. <u>381</u>		PRIMARY REG. DIST. NO. <u>43-13</u>		Registrar's No. <u>43</u>	
1. PLACE OF DEATH a. COUNTY <u>SULLIVAN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>GRUNDY</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>MILAN,</u>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>GALT, MISSOURI</u> <u>0400</u>			
c. LENGTH OF STAY (in this place) <u>5 days</u>							
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>SULLIVAN COUNTY MEMORIAL</u>				d. STREET ADDRESS (If rural, give location) <u>/</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>KATHRYN</u>		b. (Middle) <u>E</u>		c. (Last) <u>ALTISER</u>	
4. DATE OF DEATH		(Month) <u>6-18-</u>		(Day) <u>1955</u>		(Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 23, 1883</u>	9. AGE (In years last birthday) <u>71</u>	10. UNDER 1 YEAR Months <u>7</u> Days <u>26</u>	11. UNDER 12 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>SULLIVAN CO. MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13a. FATHER'S NAME <u>JAMES PIPES</u>		13b. MOTHER'S MAIDEN NAME <u>VIRGINIA KNIFONG</u>		14. NAME OF HUSBAND OR WIFE <u>C. L. ALTISER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>C. L. ALTISER GALT, MO.</u>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebro Sclerosis</u> DUE TO (c) <u>331X</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>2 de</u> <u>?</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) (Min.) _____		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 <u>1-1-</u> , 19 <u>55</u> , to <u>6-18-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-17-</u> , 19 <u>55</u> , and that death occurred at <u>12:45</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>H. C. Weston M.D.</u> (Degree or title)				23b. ADDRESS <u>Galt, Mo.</u>		23c. DATE SIGNED <u>6-25-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>June 21 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Humphreys, Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Humphreys, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>6-23-1955</u>		REGISTRAR'S SIGNATURE <u>Mrs. H. B. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>R. K. Payne Galt Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

JUL 1958

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 _____

Licensed Embalmer No. 3400

P. O. Address Galt

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.