

FILED APR 9 - 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8940

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>3025</u>		Registrar's No. <u>70</u>	
1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>			
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN <u>West Plains, Mo.</u>		c. LENGTH OF STAY (in this place) <u>246/0</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains, Mo.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Christa Hogan Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>205 Thayer Avenue</u>			
3. NAME OF DECEASED (Type or Print), a. (First) <u>CATHERINE</u>		b. (Middle) <u>--</u>		c. (Last) <u>FEWELL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 31, 1956</u>	
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>July 10, 1873</u>	9. AGE (in years last birthday) <u>82</u>	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) <u>homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>French Camp, Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John Bryan</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Carter</u>		14. NAME OF HUSBAND OR WIFE <u>J. R. Fewell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Les Alsworth, Cassville, Missouri</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>Hemiplegia (Rt) Central Hemorrhage Lower</u> ANTECEDENT CAUSES <u>Cardiac Decompensation &amp; Edema</u> <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Hypertension, chr. Severe</u> DUE TO (c) <u>Arteriosclerosis, chr.</u>				INTERVAL BETWEEN ONSET AND DEATH _____	
II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</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) <u>443x</u>			
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>27 Dec, 1955</u> to <u>31 Mar, 1956</u> that I last saw the deceased alive on <u>30/3</u> , 19 <u>56</u> , and that death occurred at <u>6:35a</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or Title) <u>[Signature]</u>		23b. ADDRESS <u>West Plains, Mo</u>		23c. DATE SIGNED <u>APR 3 - 1956</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>Apr. 1, 1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>West Plains, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>4-3-56</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hal Shaw Gough</u>		ADDRESS <u>West Plains, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

STATEMENT OF LICENSED EMBALMER

NAME OF DECEASED		DATE OF DEATH	
RESIDENCE OF DECEASED		CITY AND COUNTY	
PLACE OF DEATH		CAUSE OF DEATH	
PLACE OF BURIAL		DATE OF BURIAL	
NAME OF FUNERAL HOME		NAME OF EMBALMER	
ADDRESS OF FUNERAL HOME		ADDRESS OF EMBALMER	
CITY AND COUNTY OF FUNERAL HOME		CITY AND COUNTY OF EMBALMER	
STATE OF FUNERAL HOME		STATE OF EMBALMER	
DATE OF STATEMENT		SIGNATURE OF EMBALMER	

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

or

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student-Embalmer \_\_\_\_\_

Signed *Hal Kambourgh*

Licensed Embalmer No. *3408*

P. O. Address *West Plains*

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.