

Health,
Welfare
Public
Service

FILED MAR 11 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 362 Primary Registration District No. 4531 Registrar's No. 36

300
-57

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1. PLACE OF DEATH a. COUNTY <u>Warren</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Warrenton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Charles</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Katie Jane Home</u>		Length of stay in lb <u>7 Months</u>	d. STREET ADDRESS (If outside, give location) <u>314 S.2nd St.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Clinton</u> Middle <u>S.</u> Last <u>Whiteside</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>17,</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1920</u>	9. AGE (In years last birthday) <u>37</u>	10. F UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE (Invalid)</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Miami, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Stanley Whiteside</u>		13b. MOTHER'S MAIDEN NAME <u>Jesse Dixson</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</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. <u>NONE</u>	17. INFORMANT Address <u>Jessie I. Whiteside, St. Charles, Mo</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Verdict of Coroner's Jury.</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Death due to fire at Katie Jane Home, about 2:35 P.M.</u>	
	DUE TO (c) <u>Origin of fire undetermined.</u>	<u>9:167</u> <u>40</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Burning of Katie Jane Home</u>	
20c. TIME OF INJURY Hour <u>2</u> Minute <u>35</u> p.m. Month <u>2</u> Day <u>17</u> Year <u>57</u>			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>	20f. CITY, TOWN, OR LOCATION <u>Warrenton</u>	COUNTY <u>Warren</u> STATE <u>Mo</u>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <u>D. E. A. Krigger</u> (Degree or title) <u>3</u>	22b. ADDRESS <u>Warrenton, Missouri</u>	22c. DATE SIGNED <u>3-10-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-22-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>St. Charles, Mo.</u>
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24. FUNERAL DIRECTOR <u>C.L. Prinster, St. Charles, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>3-10-57</u>	26. REGISTRAR'S SIGNATURE <u>Floyd Logan</u>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

7387

MAR 21 1957

MAR 22 1957

MAR 13 1957

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 *John Shalung*

Licensed Embalmer No. 3897

P. O. Address *Warrenton, M*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.