

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **23520**

FILED JUL 31 1957

BIRTH NO. _____		REG. DIST. NO. 32		PRIMARY REG. DIST. NO. 5110		Registrar's No. 44	
1. PLACE OF DEATH a. COUNTY BOLLINGER				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE MISSOURI b. COUNTY BOLLINGER			
b. CITY OR TOWN FILLMORE TOWNSHIP		c. LENGTH OF STAY (in this place) 11 YRS		c. CITY OR TOWN RURAL FILLMORE TOWNSHIP		e. 090	
d. FULL NAME OF HOSPITAL OR INSTITUTION R. F. D. #1 GLEN ALLEN				d. STREET ADDRESS (If rural, give location) R. F. D. #1 GLEN ALLEN			
3. NAME OF DECEASED a. (First) FRANCIS b. (Middle) AUGUST c. (Last) CAUTTRELL				4. DATE OF DEATH (Month) (Day) (Year) JULY 16 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH JAN. 11 1880	
9. AGE (In years last birthday) 77		10. UNDER 1 YEAR Months Days		11. UNDER 100 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) TENNESSEE		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME John Cauttrell		13b. MOTHER'S MAIDEN NAME Don't Know		14. NAME OF HUSBAND OR WIFE MARY SUSAN CAUTTRELL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME FAREST CAUTTRELL ADDRESS GLEN ALLEN 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) possible carcinomatosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Marked generalized and cerebral arteriosclerosis.				INTERVAL BETWEEN ONSET AND DEATH 1 week. 26 mos.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		1999		20. AUTOPSY? 2 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) (Min.) _____		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 July 10, 1957 , to July 16, 1957 , that I last saw the deceased alive on July 16, 1957 , and that death occurred at 10:00 PM. , from the causes and on the date stated above.							
23a. SIGNATURE Dr. Bruce, MD (Degree or title)				23b. ADDRESS Marble Hill, Mo.		23c. DATE SIGNED 7/17/57	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE JULY 20 1957		24c. NAME OF CEMETERY OR CREMATORY FRIEND		24d. LOCATION (City, town, or county) (State) ORAN MO.	
DATE REC'D BY LOCAL REG. 7/27/57		REGISTRAR'S SIGNATURE Mrs. Buford Crader		25. FUNERAL DIRECTOR'S SIGNATURE Carl J. Smith		ADDRESS ORAN MO.	

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Signed _____
Student Embalmer

Licensed Embalmer No. 2676

P. O. Address Ocean 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.