

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32964

STATE FILE NUMBER

FILED SEP 26 1957

Registration District No. 278 Primary Registration District No. 2054 Registrar's No. 108

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1-57  
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1. PLACE OF DEATH a. COUNTY <u>PIKE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>PIKE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LOUISIANA</u>		c. CITY OR TOWN <u>LOUISIANA</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PIKE CO. HOSP.</u>		d. STREET ADDRESS (If outside, give location) <u>722 NORTH CAROLINA</u>	
Length of stay in 1b <u>3 DAYS</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>BEULAH BENTON CHATBOURN</u>			4. DATE OF DEATH Month Day Year <u>SEPT 16, 1957</u>		
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 1, 1870</u>	9. AGE (In years last birthday) <u>87</u>	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.
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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>HOME</u>	11. BIRTHPLACE (City and state or country) <u>PIKE CO., MO.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>JOHN W. COLE</u>	13b. MOTHER'S MAIDEN NAME <u>LOUISA TINKER</u>	14. NAME OF HUSBAND OR WIFE
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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 <u>MRS SHORENE REID, PARKVILLE, MO.</u>
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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>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Acute Congestive Heart Disease</u>		<u>1 yr</u>
	DUE TO (c) <u>Cardiac Hypertrophied</u>		<u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>General Arterio Sclerosis - 4201</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. ACCIDENT <input 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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20d. INJURY OCCURRED WHILE AT <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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from 9/9/57 to 9/16/57 and last saw her alive on 9/16/57  
Death occurred at 6:40 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert L. Anderson M.D.</u> (Degree or title) <input type="checkbox"/>	22b. ADDRESS <u>Louisiana, Mo</u>	22c. DATE SIGNED <u>9/19/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>SEPT 19, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>LOUISIANA, MO.</u>
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24. FUNERAL DIRECTOR <u>GEO. M. COLLIER, LOUISIANA, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>Sept 19, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1 MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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OCT 9 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 *Geo M. Collier* .....

Licensed Embalmer No. *3839* .....  
P. O. Address *Louisiana* .....

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.