

pt. Health,
S. & Welfare
S. Public
Health Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40130
STATE FILE NUMBER

FILED DEC 9 - 1957

Registration District No. 141 Primary Registration District No. 3035 Registrar's No. 44

1. PLACE OF DEATH a. COUNTY <u>Monroe</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Monroe</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>West Plains</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Pomona</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) <input checked="" type="checkbox"/> HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/>		Length of stay in 1b	d. STREET ADDRESS <u>R. J. St</u> (If outside, give location) Residence <u>2466</u> Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Lewis</u> Last <u>Christopher</u>			4. DATE OF DEATH Month <u>11</u> Day <u>29</u> Year <u>57</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	9. AGE (In years) <u>75</u> IF UNDER 1 YEAR: Months <u>8</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>
11. BIRTHPLACE (City and state or country) <u>St Charles Co., Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Ted Christopher</u>		13b. MOTHER'S MAIDEN NAME <u>Melinda Lewis</u>	14. NAME OF HUSBAND OR WIFE <u>Norm M. Christopher</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT <u>Ruth Brown, West Plains, Mo</u> Address <u></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>Myocardial Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>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.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/> AT WORK	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY _____ STATE _____
21. I attended the deceased from <u>13 Nov 1957</u> to <u>29 Nov 1957</u> and last saw him alive on <u>28 Nov 1957</u> Death occurred at <u>12:10 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>George Christopher</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>West Plains, Mo.</u>	22c. DATE SIGNED <u>NOV 30 1957</u>
23a. BURIAL, CREMATION, REBURY (Specify)	23b. DATE <u>12-1-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Leon</u>	23d. LOCATION (City, town, or country) (State) <u>West Plains, Mo</u>
24. FUNERAL DIRECTOR <u>Robertson Mortuary, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>12-6-57</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
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.

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 *D. Skenton*

Licensed Embalmer No. *3437*

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