

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43163

FILED DEC 2 - 1957

STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 6093 Registrar's No. 225

V. S. 300
ev. 1-57

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1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Houstonia</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>Missouri State School Hospital</u>		Length of stay in lb <u>23 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>0976</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Julius</u> Middle <u>---</u> Last <u>Kateman</u>			4. DATE OF DEATH Month <u>November</u> Day <u>29</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>5-29-1934</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	9. AGE (In years last birthday) <u>23</u> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>Blackwater, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Quenton W. Kateman</u>		13b. MOTHER'S MAIDEN NAME <u>Cecil Hall Biggs</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>Mo. School, Marshall</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE OF Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Acute Pneumonia</u> DUE TO (c) <u>Influenza, acute</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 days</u> <u>10 days</u>
PART II. - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>480X</u>			19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" 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 <u>7:55</u> Month <u>Sept</u> Day <u>5</u> Year <u>57</u> a.m. p.m.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Arrow Rock</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <u>Marshall, Mo.</u> COUNTY STATE	
21. I attended the deceased from <u>Sept 55</u> to <u>29 Nov 57</u> and last saw her alive on <u>29 Nov 57</u> . Death occurred at <u>7:55 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>L. Lee McTorkle M. C.</u>		22b. ADDRESS <u>Marshall, Mo.</u>	
22c. DATE SIGNED <u>11-29-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/1/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arrow Rock</u>	23d. LOCATION (City, town, or county) (State) <u>Arrow Rock Mo.</u>
24. FUNERAL DIRECTOR <u>J. Leahi Young - Marshall, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-30-57</u>	26. REGISTRAR'S SIGNATURE <u>Cecil H. Reed</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.

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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 William Freed

Licensed Embalmer No. 4733

P. O. Address Marshall

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.