

FILED DEC 31 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45481
STATE FILE NUMBER

Registration District No. 311 Primary Registration District No. 4456 Registrar's No. 41

V. S. 300
Rev. 1-57

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|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>ST CLAIR</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST CLAIR</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>APPLETON CITY</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>OSCEOLA</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ELLIOT MEM-HOSP</u> | | Length of stay in 1b <u>6 weeks</u> | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Middle Last <u>CATHERINE - RATHBUN</u> | | | 4. DATE OF DEATH Month Day Year <u>12-23-57</u> | | |
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| 5. SEX <u>7</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>5-22-1872</u> | 9. AGE (In years last birthday) <u>85</u> | IF UNDER 1 YEAR Months Days | IF 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>Housekeeper</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Unknown</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
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| 13a. FATHER'S NAME <u>Unknown</u> | 13b. MOTHER'S MAIDEN NAME <u>Unknown</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, Address <u>ST CLAIR CO WIZARD OFFICE</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>Cerebral Hemorrhage</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>Cerebral arteriosclerosis</u> | |
| | DUE TO (c) _____ | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331X</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 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. | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>8:00 AM 57</u> to <u>2:30 AM 57</u> and last saw ^{him} alive on <u>22 Dec 57</u> Death occurred at <u>6:30 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) <u>Walter M. ...</u> | 22b. ADDRESS <u>Appleton City</u> | 22c. DATE SIGNED <u>23 Dec 57</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>12-27-57</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>LOWRY CITY</u> | 23d. LOCATION (City, town, or county) (State) <u>LOWRY CITY MO</u> |
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| 24. FUNERAL DIRECTOR <u>Frederick Home</u> | ADDRESS <u>OSCEOLA MO</u> | 25. DATE RECD. BY LOCAL REG. <u>Dec. 26, 1957</u> | 26. REGISTRAR'S SIGNATURE <u>Chas. Atney</u> |
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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

85

MAY 28 1958

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 *[Handwritten Signature]*

Licensed Embalmer No. *3038*

P. O. Address *[Handwritten Address]*

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.