

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022123

FILED JUL 7 1959 Registration District No. 187 Primary Registration District No. 328 STATE FILE NUMBER 59-022123 Registrar's No. 168

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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Livingston</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <b>Missouri</b> b. COUNTY <b>Livingston</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fairview Twp.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Fairview Twp.</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>11 Mi. S.E. of Chillicothe</b>		Length of stay in lb <b>few min.</b>	d. STREET ADDRESS (If outside, give location) <b>11 Mi. S.E. of Chillicothe</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>CLYDE</b> Last <b>PLASTER</b>			4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 14, 1891</b>
9. AGE (In years (at birthday)) <b>68</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	11. BIRTHPLACE (City and state or country) <b>Coloma, Missouri</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>John Gaylord Plaster</b>		13b. MOTHER'S MAIDEN NAME <b>Rosetta McCracken</b>	14. NAME OF HUSBAND OR WIFE <b>Catherine Allen</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>RR#2</b> <b>Mrs. Catherine Plaster Chillicothe, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Confusion Severe of Brain</b> <b>Fractured Skull</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Instant</b> DUE TO (c) <b>Instant</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <b>Tractor Turned over &amp; squashed his head</b>	
20c. TIME OF INJURY Hour <b>1:45 p.m.</b> Month, Day, Year <b>June 26 '59</b>		20d. INJURY OCCURRED WHILE AT <input checked="" type="checkbox"/> HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> <b>on road</b>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>on road</b>		20f. CITY, TOWN, OR LOCATION <b>Chillicothe Livingston, Mo.</b>	
21. I attended the deceased from <b>None</b> to <b>him</b> and last seen <b>him</b> on <b>June 26 '59</b> Death occurred at <b>1:45 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>Joseph C. Cannon M.D.</b>	
22b. ADDRESS <b>Chillicothe, Mo.</b>		22c. DATE SIGNED <b>July 2 '59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6-29-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Avalon Cemetery</b>
23d. LOCATION (City, town, or county) <b>Avalon, Missouri</b>		24. FUNERAL DIRECTOR <b>NORMAN FN'L. HOME: Chillicothe, Mo.</b>	
25. DATE RECD. BY LOCAL REG. <b>7-2-59</b>		26. REGISTRAR'S SIGNATURE <b>Francis B Neill</b>	

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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 LINDA L. BOLIN, Student Embalmer No. 573 working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed John Bolin.....

Licensed Embalmer No. 5035.....  
P. O. Address Chillicothe, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.