

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033000

FILED VS OCT 13 1959

187

Primary Registration District No. 3044

Registrar's No. 241

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>Livingston</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Livingston</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Chillicothe</b>		Length of stay in 1b <b>Life</b>		c. CITY OR TOWN <b>Chillicothe</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>818 Leeper St.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>818 Leeper St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>JOHN</b> Last <b>GORMAN</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>1</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>5/9/72</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own store</b>		11. BIRTHPLACE (City and state or country) <b>Livingston Co., Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>John Gorman</b>			13b. MOTHER'S MAIDEN NAME <b>Margaret Kelly</b>		14. NAME OF HUSBAND OR WIFE <b>Adeline Gorman</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>500-36-1720</b>	17. INFORMANT Address <b>Mrs. Adeline Gorman, 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>Coronary Occlusion</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arterial Sclerosis Severe</b>							<b>3 yrs</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) <b>Prostatectomy (Hypertrophied) 1953</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 a.m. p.m.	Month, Day, Year						
20d. INJURY OCCURRED WHILE AT WORK <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
21. I attended the deceased from <b>Febr 10 - 48</b> to <b>Oct 1 - 59</b> and last saw him alive on <b>Sept 29 - 59</b> Death occurred at <b>12:30 P</b> m on the date stated above, and to the best of my knowledge from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Joseph A. Conrad M.D.</b>				22b. ADDRESS <b>Chillicothe, Mo</b>		22c. DATE SIGNED <b>Oct 7 - 59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>10/3/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Catholic cemetery</b>		23d. LOCATION (City, town, or county) <b>Chillicothe, Mo.</b>			
24. FUNERAL DIRECTOR <b>Donald Gordon, Chillicothe, Mo.</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Oct 17/59</b>		26. REGISTRAR'S SIGNATURE <b>Frances B Neill</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Richard H. Banda

Licensed Embalmer No. 4866

P. O. Address Chillicothe

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.