

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 2 1960

=60-016092

INDEXED

Registration District No. 157 Primary Registration District No. \_\_\_\_\_ Registrar's No. 83

STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Livingston</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chula</u>		Length of stay in 1b <u>20 yrs.</u>		e. STATE <u>Missouri</u> COUNTY <u>Livingston</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Family home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Chula</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
				d. STREET ADDRESS (If outside, give location) <u>No street address</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>John</u>		Middle <u>Douglas</u>		Last <u>Catron</u>		Month <u>April</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>10/1/97</u>	9. AGE (last birthday) <u>62</u>	IF UNDER 1 YEAR	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucking</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hauling stock and farm produce</u>		11. BIRTHPLACE (City and state or country) <u>Menefee Co., Ky.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Robert W. Catron</u>			13b. MOTHER'S MAIDEN NAME <u>Mary E. Lawson</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Catron</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>487-42-5412</u>		17. INFORMANT Address <u>Mrs. Mary Catron, Chula, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u>						<u>10 days</u>	
DUE TO (b) <u>Generalized arteriosclerosis</u>						<u>unknown</u>	
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>Paralysis agitans 15 years</u>						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 <u>Nov. 14 59</u> to <u>April 24, 1960</u> and last saw him alive on <u>April 18, 1960</u> Death occurred at _____ <u>3:30A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>William L. Fair, M.D.</u>				22b. ADDRESS <u>Chillicothe, MO</u>		22c. DATE SIGNED <u>4/26/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Apr. 26, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Catholic cemetery</u>		23d. LOCATION (City, town, or county) <u>Chillicothe, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Donald Gordon, Chillicothe, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>4/26/60</u>		26. REGISTRAR'S SIGNATURE <u>Frances B Krell</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

3021 0

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Richard W. Bandall

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.