

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034069

FILED VS SEP 20 1960

53

3010

360

STATE FILE NUMBER

INDEXED

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

|  |                                       |  |   |
|--|---------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Cape Girardeau</b>                                 |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence Before admission)<br>a. STATE <b>Ill.</b> b. COUNTY <b>Union</b> |   |
| b. CITY (if outside corporate limits, give TOWNSHIP only)<br><b>Cape Girardeau</b>   | Length of stay in 1b<br><b>2 Days</b> | c. CITY OR TOWN<br><b>Anna</b>   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br><b>Southeast Mo. Hospital</b> |                                       | d. STREET ADDRESS (If outside, give location)<br><b>104 1/2 Lincoln</b>  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|  |                              |  |   |  |  |
|--|------------------------------|--|---|--|--|
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Kathryn</b> Middle <b>L.</b> Last <b>Craver</b>                       |                              |  | 4. DATE OF DEATH<br>Month <b>Sept</b> Day <b>8</b> Year <b>1960</b>     |  |  |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan 27, 1881</b>                                 | 9. AGE (last birthday)<br><b>79</b>        | IF UNDER 1 YEAR<br>Months _____ Days _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>          |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   | 11. BIRTHPLACE (City and state or country)<br><b>Union County, Ill.</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |  |
| 13a. FATHER'S NAME<br><b>Unknown</b>   |                              | 13b. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>None</b> |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> |                              | 16. SOCIAL SECURITY NO.<br><b>None</b>   | 17. INFORMANT<br><b>Kathryn Mixen Jonesboro, Ill.</b>                   |  |  |

|   |            |   |
|---|------------|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b> |            | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (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)<br><b>Congestive Heart Failure</b> |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
|--|--|--|--|

|   |   |  |  |
|---|---|--|--|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>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<br><b>Anna</b> COUNTY <b>Ill.</b> STATE <b>Ill.</b> |

21. I attended the deceased from **9-6-60** to **9-8-60** and last saw her/him alive on **9-8-60**  
Death occurred at **9:15 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

|  |   |  |
|--|---|--|
| 22a. SIGNATURE<br><b>Charles F. Smith M.D.</b> (Degree or title) | 22b. ADDRESS<br><b>Cape Girardeau, Mo</b> | 22c. DATE SIGNED<br><b>9/9/60</b>                          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>       | 23b. DATE<br><b>Sept 11, 1960</b>         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Anna Cemetery</b> |
| 23d. LOCATION (City, town, or county)<br><b>Anna Ill.</b>        |   |  |

|   |   |   |
|---|---|---|
| 24. FUNERAL DIRECTOR<br><b>Crain - Norris, Anna, Ill.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>Sept. 12, 1960</b> | 26. REGISTRAR'S SIGNATURE<br><b>Ernest Kasten</b> |
|---|---|---|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH  
No. \_\_\_\_\_  
Date of Death \_\_\_\_\_  
Place of Death \_\_\_\_\_  
Cause of Death \_\_\_\_\_  
Manner of Death \_\_\_\_\_  
Age at Death \_\_\_\_\_  
Sex \_\_\_\_\_  
Race \_\_\_\_\_  
Marital Status \_\_\_\_\_  
Occupation \_\_\_\_\_  
Education \_\_\_\_\_  
Religion \_\_\_\_\_  
Usual Residence \_\_\_\_\_  
Place of Birth \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Sex of Mother \_\_\_\_\_  
Date of Birth of Mother \_\_\_\_\_  
Name of Mother \_\_\_\_\_  
Name of Father \_\_\_\_\_  
Date of Birth of Father \_\_\_\_\_  
Name of Spouse \_\_\_\_\_  
Date of Birth of Spouse \_\_\_\_\_  
Name of Spouse's Mother \_\_\_\_\_  
Date of Birth of Spouse's Mother \_\_\_\_\_  
Name of Spouse's Father \_\_\_\_\_  
Date of Birth of Spouse's Father \_\_\_\_\_  
Name of Spouse's Spouse \_\_\_\_\_  
Date of Birth of Spouse's Spouse \_\_\_\_\_  
Name of Spouse's Spouse's Mother \_\_\_\_\_  
Date of Birth of Spouse's Spouse's Mother \_\_\_\_\_  
Name of Spouse's Spouse's Father \_\_\_\_\_  
Date of Birth of Spouse's Spouse's Father \_\_\_\_\_

SEP 21 1960

**STATEMENT BY LICENSED EMBALMER**

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 Neil H. Grosshede

Licensed Embalmer No. 4994

P. O. Address Cape Girardeau

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.