

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri			Length of stay in 1b 15 days		c. CITY OR TOWN Burke City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) 209 Connolly Dr.	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ada Middle Marie Last Cato				4. DATE OF DEATH Month January Day 15 , Year 1961			
5. SEX F	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-12-1896	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during 14 days preceding life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) Huntingburg, Ind.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Thomas Cato			13b. MOTHER'S MAIDEN NAME Margaret Roach			14. NAME OF HUSBAND OR WIFE James P. Cato	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address James P. Cato-209 Connolly Dr., Burke City 21		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of the liver							INTERVAL BETWEEN ONSET AND DEATH 1 yr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							581-0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Dec. 31-1960 to Jan. 15-1961 and last saw her alive on Jan. 15-1961				Death occurred at 8:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) F.R. Bradley M.D. Frank R. Bradley, M.D.				22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 1/15/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-18-1961		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		23d. LOCATION (City, town, or county) (State) Pagedale, Mo.	
24. FUNERAL HOME ADDRESS BAUMANN BROS. INC. FUNERAL HOME 2504 WOODSON ROAD				25. DATE RECD. BY LOCAL REG. JAN 17 1961		26. REGISTRAR'S SIGNATURE Roald Smith, M.D.	

STATEMENT BY LICENSED EMBALMER

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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 David C. Gibson

Licensed Embalmer No. 3454
P. O. Address Overland

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.