

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037669

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 194

1. PLACE OF DEATH
 a. COUNTY **LIVINGSTON**
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **CHILLICOTHE** Length of stay in 1b **1 MONTH**
 c. CITY OR TOWN **CHILLICOTHE** Inside Limits Yes No
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **MILLER'S REST HOME** Inside Limits Yes No
 d. STREET ADDRESS **212 RYAN ST.** (If outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED First **TOM** Middle **CLINTON** Last **WAGNER**
4. DATE OF DEATH Month **NOVEMBER** Day **1** Year **1961**

5. SEX **MALE** **6. COLOR OR RACE** **WHITE** **7. Married** **Never Married** **Widowed** **Divorced**
8. DATE OF BIRTH **6/19/1871** **9. AGE (last birthday)** **90** **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, or if retired) **RETIRED CARPENTER** **10b. KIND OF BUSINESS OR INDUSTRY** **BUILDING** **11. BIRTHPLACE** (City and state or country) **UNKNOWN** **12. CITIZEN OF WHAT COUNTRY** **U.S.A.**

13a. FATHER'S NAME **UNKNOWN** **13b. MOTHER'S MAIDEN NAME** **UNKNOWN** **14. NAME OF HUSBAND OR WIFE** **MADIE ALICE BOONE**

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** **BRUCE FURGESON** Address **309 10th St. CHILLICOTHE MO**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) *Chronic Myocarditis*
 DUE TO (b) *Arteriosclerosis*
 DUE TO (c) _____
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO
20a. ACCIDENT **SUICIDE** **HOMICIDE**
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 **NOT WHILE AT WORK**
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 *Sept 26-61* to *Nov 1-61* and last saw *her* him alive on *Oct 31-1961*
 Death occurred at *3:45* *Am* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE *[Signature]* (Degree or title) _____ **22b. ADDRESS** *Chillicothe mo* **22c. DATE SIGNED** *11-1-61*

23a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** **23b. DATE** *11/4/61* **23c. NAME OF CEMETERY OR CREMATORY** **MT. PLEASANT CEMETERY** **23d. LOCATION** (City, town, or county) (State) **LIVINGSTON COUNTY, MO.**

24. FUNERAL DIRECTOR **NORMAN FUNERAL HOME: Chillicothe, Mo.** **25. DATE RECD. BY LOCAL REG.** *Nov. 1, 1961* **26. REGISTRAR'S SIGNATURE** *Annalee Taylor*

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

NOV 14 1961

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 Elton Norman

Licensed Embalmer No. 4036

P. O. Address CHILlicothe, MISS

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.