

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 23 1957

STATE FILE NUMBER **31568**

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 594

1. PLACE OF DEATH a. COUNTY <u>Henry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Clinton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Clinton Gen. Hosp.</u>			Length of stay in 1b <u>life</u>		d. STREET ADDRESS (If outside, give location) <u>504 Flora</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHERINE LEE ANDERSON</u>				4. DATE OF DEATH Month Day Year <u>Sept 18 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8 1897</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>3 18 - -</u>	IF UNDER 24 HRS. <u>- -</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>tax collector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Waverly Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Callaway</u>				14. MOTHER'S MAIDEN NAME <u>Susan Frances Edwards</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (es. no. or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Berny Anderson Kansas City, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF COLON</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 YR</u>	
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)						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.) <u>153X</u>	
20c. TIME OF INJURY Hour : Month, Day, Year a. m. p. m.							
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>1953</u> to <u>18 SEPT. 1957</u> and last saw her alive on <u>17 SEPT. 1957</u> Death occurred at <u>6:45</u> A. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deputy or title) <u>Hugh B. Walker, MD</u>				22b. ADDRESS <u>Clinton, Mo</u>		22c. DATE SIGNED <u>18 Sept. 1957</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Sept 20, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Englewood</u>		23d. LOCATION (City, town, or county) (State) <u>Clinton Mo</u>	
24. FUNERAL DIRECTOR <u>SCHABERG FUNERAL HOME</u> ADDRESS <u>Clinton Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>9-20-57</u>		26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>		

214 SO. SECOND PH. 454 (Licensed Embolmer's Statement on Reverse Side)

00-56
 diseases in Part I must be casually related. Crayon cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 Doctor, coroner, etc. must use only standard form.

FEB 10 1958

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 *F. L. Schaefer*

Licensed Embalmer No. *45*

P. O. Address *Clinton*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.