

Registration District No. 50Primary Registration District No. 3004Registrar's No. 38

## 1. PLACE OF DEATH:

(a) County Bates  
 (b) City or town Builer  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Memorial Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 week  
 (Specify whether  
 In this community 10 yrs  
 years, months or days)

3. (a) PRINT  
FULL NAMEJOHN W. CATRON3. (b) If veteran,  
name war 3. (c) Social Security  
No. 4. Sex m5. Color or  
race w6. (e) Single, widowed, married,  
divorced widower

6. (b) Name of husband or wife

6. (c) Age of husband or wife if

7. Birth date of deceased

Sept  
(Month)25  
(Day)1863  
(Year)

8. AGE:

Years

Months

Days

If less than one day

78920

hr.

min.

9. Birthplace

Monticello  
(City, town, or county)Kentucky  
(State or foreign country)

10. Usual occupation

farmer

11. Industry or business

12. Name

James Catron

13. Birthplace

Catron, Ky. Kentucky  
(City, town, or county) (State or foreign country)

14. Maiden name

Margaret Dennis

15. Birthplace

Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant

Welf Roberts

(b) Address

Atton, Ohio17. (a) removed  
(Burial, cremation, or removal)

(b) Date thereof

June 16 1941  
(Month) (Day) (Year)

(c) Place: burial or cremation

Builer, Ky.

18. (a) Signature of funeral director

Calvin

(b) Address

Builer, Mo. 6319. (a) June 16 41  
(Date received local registrar)(b) Thomas L. Catron

(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bates  
 (c) City or town none  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 0  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15  
year 1941 hour 7 minut 30 a. m.21. I hereby certify that I attended the deceased from June 9  
1941, to June 15 1941.that I last saw him alive on June 14 1941  
and that death occurred on the date and hour stated above.Immediate cause of death Internal hemorrhage  
in terminal pneumoniaDue to Internal hemorrhage  
due to pneumonia

Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:

Of operations Same findings of Internal  
X-Ray chest and cerebral  
Of autopsy nonePHYSICIAN  
Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? none  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_23. Signature E. E. Robinson (M. D. or other) 0  
Address Atton, Mo. Date signed 6-15-41

12219 JUN 30 1941

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, only  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed R. Stanton Leslie  
Licensed Embalmer No. 4123  
P. O. Address Butler, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply  
the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 21062

Registration District No. 50

Primary Registration District No. 3004

Registrar's No.

1. PLACE OF DEATH

(a) County Bates  
(b) City or town Butler  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME

John W Catron

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
77 9 20 hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name (City, town, or county) (State or foreign country)

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH Month June day 15 year 1987 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death

Intestinal obstruction

Due to Toxemia + Peritonitis

Due to Intestinal obstruction also results of Toxemia

Other conditions N.M.D.  
(Include pregnancy within 3 months of death)

Major findings: distended colon and obstruction at splenic flexure

Of autopsy non-specific  
creeping peritonitis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature E. E. Rehman (M. D. or other)

Address Admission Date signed Aug 10-1987

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

