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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26762

Registration District No. 149

Primary Registration District No. 1002.

Registrar's No. 3403

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community 12 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 606 West 17th Street 3
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME John D. Catt

3. (b) If veteran, name war None

3. (c) Social Security No. 493-12-8604

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Linday Catt

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 1 (Month) 3 (Day) 1881 (Year)

8. AGE: Years 63 | Months ~~6~~ 7 | Days ~~13~~ 11 | If less than one day hr. min.

9. Birthplace Indiana (City, town, or county) 1 (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Levi Catt
13. Birthplace No Record (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name NO Record
15. Birthplace No Record (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs Mary Turner
(b) Address 606 West 17th Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-1944 (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Mrs C.L. Forster
(b) Address 918-920 Brooklyn

19. (a) 8-18-44 (Date received local registrar) (b) R. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 14
year 44 hour 8 minute 40 A M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h Deputy Coroner , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral Confluent

Due to Bronchopneumonia

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 107

Of autopsy See Above

Duration

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature A. E. Ussher (M. D. or other) M.D.

Address 23 McCoy Date signed 8/19/44

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(Licensed Embalmer's Statement on Reverse Side)

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~~.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Theron A. Redmon

Licensed Embalmer No. 2737

P. O. Address R.C. Mo

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