

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **34580**

FILED NOV 3 1952

BIRTH NO. _____ REG. DIST. NO. **98** PRIMARY REG. DIST. NO. **5363** Registrar's No. **83**

0310

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

1. PLACE OF DEATH a. COUNTY Davies		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY Davies	
b. CITY OR TOWN Rural Jefferson Township		c. CITY OR TOWN Rural Jefferson Twp	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS Jefferson Township	

3. NAME OF DECEASED (Type or Print) a. (First) Robert b. (Middle) Mathias c. (Last) Catron			4. DATE OF DEATH (Month) (Day) (Year) 10-7-52		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH 4-27-1863	9. AGE (In years last birthday) 89	10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired farmer
10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZENSHIP OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME John Catron		13b. MOTHER'S MAIDEN NAME Elizabeth Dula Lillie Catron		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Lillian F. Catron ADDRESS Hinton Mo	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocarditis		INTERVAL BETWEEN ONSET AND DEATH Several months
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
	DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4222	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **March 19th** to **Oct 7, 1952** that I last saw the deceased alive on **Oct 7, 1952**, and that death occurred at **11 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE F. K. Wilson, M.D. (Degree or title)	23b. ADDRESS Winston Mo	23c. DATE SIGNED 10-9-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct 9-52	24c. NAME OF CEMETERY OR CREMATORY Winston	24d. LOCATION (City, town, or county) (State) Winston Mo
DATE REC'D BY LOCAL REG. 10-31-52	REGISTRAR'S SIGNATURE Regenia M. Engelhart	25. FUNERAL DIRECTOR'S SIGNATURE Rita Shoup ADDRESS Winston Mo	

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
Student Embalmer

Signed _____

Licensed Embalmer No. 3302

P. O. Address Gallatin, 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.