

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40679

STATE FILE NUMBER

FILED DEC 24 1956

42

1000

1336

Registration District No. Primary Registration District No. Registrar's No.

Health,
Welfare
Public
Service

300
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Livingston	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Chillcothe
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hsop. #2		Length of stay in 1b 1 yr. 21 days	d. STREET ADDRESS (If outside, give location) 505 Second St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last FRANK UTLEY			4. DATE OF DEATH: Month Day Year Dec. 13, 1956
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 3, 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY farm	9. AGE (In years last birthday) 82
13. FATHER'S NAME Christopher Thomas Utley		11. BIRTHPLACE (City and state or country) Livingston County, Mo.	
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	12. CITIZEN OF WHAT COUNTRY? USA
17. INFORMANT Address Margaret Warren, Dawn, Mo.		14. MOTHER'S MAIDEN NAME unknown	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia			INTERVAL BETWEEN ONSET AND DEATH 4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arteriosclerosis			
DUE TO (c) Chr-brain syndrome associate with Ch.brain disease senility			
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.)		
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 Jan. 1, 1956, to Dec. 13, 1956 and last saw her alive on Dec. 12, 1956. Death occurred at 7:30 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Forrest Thomas M.D.		22b. ADDRESS St Joseph Mo 4, State Hwy 70 2	22c. DATE SIGNED 12-13-56
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 12/13/1956	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Chillicothe, Mo.
24. FUNERAL DIRECTOR ADDRESS Heaton-Bowman St Joseph, Mo		25. DATE RECD. BY LOCAL REG. Dec. 18, 1956	26. REGISTRAR'S SIGNATURE Esther M. Allison

(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, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *William J. [Signature]*.....
Licensed Embalmer No. *415*

P. O. Address *3195 10th St*

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