

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-006767
STATE FILE NUMBER

FILED FEB 20 1958

Registration District No. 280 Primary Registration District No. 6960 Registrar's No. 7

Health, Welfare, Public Service
3001
-57

1. PLACE OF DEATH a. COUNTY <u>Platte</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Platte</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Green Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Rural Green Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Camden Point</u>		Length of stay in lb <u>Yrs.</u>	d. STREET ADDRESS <u>1 1/2 Mi. S.E. Camden Point</u>		(Reside on Farm) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Kathryn</u> Middle <u>---</u> Last <u>Bywaters</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>5</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4 1888</u>	9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Wallace, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Riley Wellingford</u>		13b. MOTHER'S MAIDEN NAME <u>(Unknown) Noland</u>		14. NAME OF HUSBAND OR WIFE <u>Richard H. Bywaters (Dec'd)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Gordon Bywaters, Camden Point, 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 sigmoid</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</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) <u>Colostomy 8-10-56</u>					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 _____ 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>Aug 1, 1956</u> to <u>Feb. 5, 1958</u> and last saw <u>her</u> alive on <u>Feb 2, 1958</u> Death occurred at <u>10 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>D. J. Feeling</u> (Degree or title) <u>D.O.</u>		22b. ADDRESS <u>Weston, Mo.</u>		22c. DATE SIGNED <u>2-6-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Camden Point Mo.</u>
24. FUNERAL DIRECTOR <u>Hope Funeral Home</u> ADDRESS <u>Gallatin, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Feb. 7-68</u>		26. REGISTRAR'S SIGNATURE <u>Bephie Rollins</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only Standard Nomenclature in writing to avoid symptoms. All diseases in Part I must be causally related.



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 *L. O. Fickerson*

Licensed Embalmer No. *3302*

P. O. Address *Ballatin*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.