

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-014923  
STATE FILE NUMBER

FILED APR 24 1958

Registration District No. 187 Primary Registration District No. 2048 Registrar's No. 117

300  
1-57

5920

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Chillicothe</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chillicothe Hospital</u>		Length of stay in 1b <u>2 days</u>	d. STREET ADDRESS (If outside, give location) <u>1120 First St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Edward Gorman</u>			4. DATE OF DEATH Month Day Year <u>4 7 58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-14-1902</u>		9. AGE (In years last birthday) <u>55</u> IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automotive</u>		11. BIRTHPLACE (City and state or country) <u>Chillicothe, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Thomas J. Gorman</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Hickey</u>	
14. NAME OF HUSBAND OR WIFE <u>Elizabeth Irene Gorman</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>494-34-9637</u>	
17. INFORMANT <u>Mrs. Elizabeth Irene Gorman</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>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</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>4201</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
20e. CITY, TOWN, OR LOCATION COUNTY STATE		20f. CITY, TOWN, OR LOCATION COUNTY STATE			
20g. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21. I attended the deceased from <u>Apr. 2-58</u> to <u>Apr. 7-58</u> and last saw him alive on <u>Apr. 7-58</u> Death occurred at <u>10:00 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph A. Conrad, M.D. (Coroner)</u>		22b. ADDRESS <u>Chillicothe, Mo</u>		22c. DATE SIGNED <u>Apr 9 58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-9-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Resthaven</u>	
23d. LOCATION (City, town, or county) <u>Chillicothe, Mo.</u>		24. FUNERAL DIRECTOR ADDRESS <u>Norman Funeral Home, Chillicothe, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4/9/58</u>	
26. REGISTRAR'S SIGNATURE <u>Francis B. Nace</u>		(Licensed Embalmer's Statement on Reverse Side)			

APR 24 1958

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 *Joseph M. Libson* .....

Licensed Embalmer No. *4769* .....

P. O. Address *Albany 311* .....

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.