

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-029605
STATE FILE NUMBER

FILED AUG 19 1958 Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 197

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1-57
592
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1. PLACE OF DEATH a. COUNTY: <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: <u>Mo.</u> b. COUNTY: <u>Carroll</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>Carrollton</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: <u>Susan Nursing Home</u>		Length of stay in 1b <u>2 wks</u>	d. STREET ADDRESS (If outside, give location) <u>202 N. Folger</u>
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First: <u>ANNA</u> Middle: <u>CHRISTMAN</u> Last: <u>CHRISTMAN</u>			4. DATE OF DEATH Month: <u>Aug.</u> Day: <u>11</u> Year: <u>1958</u>		
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5. SEX: <u>Fe</u>	6. COLOR OR RACE: <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH: <u>Oct 27 1875</u>	9. AGE (In years last birthday): <u>82</u>	IF UNDER 1 YEAR: Months: <u>8</u> Days: <u>2</u>	IF UNDER 24 HRS.: Hours: <u>0</u> Min: <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>at home</u>	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (City and state or country): <u>Cleveland Ohio</u>	12. CITIZEN OF WHAT COUNTRY?: <u>U.S.A.</u>
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13a. FATHER'S NAME: <u>Frank Denman</u>	13b. MOTHER'S MAIDEN NAME: <u>Martha Scott</u>	14. NAME OF HUSBAND OR WIFE: <u>Henry Christman</u>
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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>Mrs. George Brotherton</u>	Address: <u>Carrollton, Mo.</u>
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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>Pneumonia Terminal Bronchial</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterial Sclerosis Severe</u>	DUE TO (c) <u>4500</u>	
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.)
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20c. TIME OF INJURY Hour: <u>9:00</u> Month: <u>Aug</u> Day: <u>5</u> Year: <u>58</u> a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION: <u>Carrollton</u> COUNTY: <u>Mo.</u> STATE: <u>Mo.</u>
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21. I attended the deceased from <u>Aug 5-58</u> to <u>Aug 11-58</u> and last saw <u>her</u> alive on <u>Aug 9-58</u> Death occurred at <u>9:00</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	22a. SIGNATURE: <u>Joseph P. Conrad M.D.</u> (Degree or title)	22b. ADDRESS: <u>Chillicothe, Mo.</u>	22c. DATE SIGNED: <u>Aug 12-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	23b. DATE: <u>Aug 13 1958</u>	23c. NAME OF CEMETERY OR CREMATORY: <u>Oak Hill Cem.</u>	23d. LOCATION (City, town, or county) (State): <u>Carrollton Mo.</u>
24. FUNERAL DIRECTOR: <u>Standley Gibson</u>	ADDRESS: <u>Carrollton Mo.</u>	25. DATE RECD. BY LOCAL REG.: <u>Aug 12, 58</u>	26. REGISTRAR'S SIGNATURE: <u>Frances B Neill</u>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Ben W. Gibson*

Licensed Embalmer No. *2961*

P. O. Address *Carrollton*

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.