

Health & Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036211  
STATE FILE NUMBER

8  
FILED NOV 3 1958 Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 72

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1-57

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ALL DISASES IN PART I MUST BE CAUSALLY RELATED.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Wheeler</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wheeler</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>West Plains</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>West Plains</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wheeler Hospital</u>			Length of stay in lb <u>5 min</u>		0460 STREET ADDRESS <u>Kebo Rd</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>Cathcart</u> Last <u></u>				4. DATE OF DEATH Month <u>10</u> Day <u>17</u> Year <u>58</u>				
5. SEX <u>mo</u>	6. COLOR OR RACE <u>w</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>5/4-1895</u>		9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Keokuk Co, Ia.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>J. C. Cathcart</u>		13b. MOTHER'S MAIDEN NAME <u>Minnie Mark</u>		14. NAME OF HUSBAND OR WIFE <u>Paulah Cathcart</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Was no. of months) (If yes, give war or dates of service) <u>yes war</u>			16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Paulah Cathcart</u> Address <u>West Plains 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>Hematopneumothorax</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>crush syndrome</u>							<u>1 hr</u>	
DUE TO (c) <u></u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Compound fracture of left tibia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input checked="" 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.) <u>046</u>					
20c. TIME OF INJURY Hour <u>10</u> Month <u>10</u> Day <u>17</u> Year <u>58</u> a.m. <u>am</u> p.m. <u>pm</u>			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>046</u>					
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			20f. CITY, TOWN, OR LOCATION <u>West Plains</u>		COUNTY <u>Wheeler</u>		STATE <u>MO</u>	
21. I attended the deceased from <u>10/17/58</u> to <u>10/17/58</u> and last saw him alive on <u>10/17/58</u> Death occurred at <u>11:00 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>M. L. Fowler MD</u> (Degree or title)				22b. ADDRESS <u>West Plains Mo</u>		22c. DATE SIGNED <u>10/27/58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1/10</u>		23b. DATE <u>10-19-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		23d. LOCATION (City, town or county) (State) <u>West Plains Mo</u>			
24. FUNERAL DIRECTOR <u>Keokuk West Plains Mo</u>			ADDRESS <u>10-29-58</u>		25. DATE RECD. BY LOCAL REG. <u>10-29-58</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	

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### 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 *A. A. Roberts* .....

Licensed Embalmer No. *3430* .....

P. O. Address *West* .....

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.