

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-039749

STATE FILE NUMBER

FILED NOV 24 1958

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 76

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>HOWELL</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>HOWELL</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WEST PLAINS,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>WILLOW SPRINGS,</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>CHRISTA HOGAN</b>		Length of stay in lb <b>24 hrs.</b>	d. STREET ADDRESS (If outside, give location) <b>RTE., 2,</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>KATHERYN LUCILLE CROTTEAU</b>			4. DATE OF DEATH Month <b>10</b> Day <b>23</b> Year <b>58</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-9-1914</b>	9. AGE (In years last birthday) <b>44</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FILLING STATION OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>KNOXVILLE, TENN.,</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13a. FATHER'S NAME <b>JNO. R. MONDAY</b>		13b. MOTHER'S MAIDEN NAME <b>MARGARET D. SNIDER</b>		14. NAME OF HUSBAND OR WIFE <b>HARRY J. CROTTEAU</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>X</b>		16. SOCIAL SECURITY NO. <b>YES</b>		17. INFORMANT Address <b>NOVELLA VALSVIK, WILLOW SPRINGS, MO.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>					INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive cardiovascular renal disease</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) <b>442X</b>					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. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT <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>10/22/58</u> to <u>10/23/58</u> and last saw her/him alive on <u>10/23/58</u> Death occurred at <u>5:45 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>M. L. Fowler MD</b>			22b. ADDRESS <b>West Plains Mo</b>		22c. DATE SIGNED <b>10/29/58</b> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		23b. DATE <b>10-26-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HOWELL COUNTY MEMORIAL PARK</b>		23d. LOCATION (City, town, or county) <b>POMONA, MO</b>
24. FUNERAL DIRECTOR <b>ROBERTSONS, WEST PLAINS, MO.</b>			25. DATE RECD. BY LOCAL REG. <b>11-17-58</b>		26. REGISTRAR'S SIGNATURE <b>Beatrice Cook</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

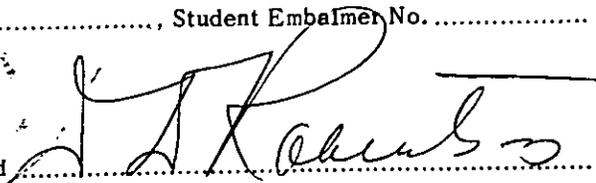
MEDICAL CERTIFICATION

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  .....

Licensed Embalmer No. 3437  
P. O. Address West Hill

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.