

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010101
State File No.

FILED MAR 30 1959

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 88

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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, write RURAL and give township) OR TOWN <u>Chillicothe</u>	c. LENGTH OF STAY (In this place) <u>65 years</u>	c. CITY OR TOWN <u>Chillicothe</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>City Hospital</u>		STREET ADDRESS (If rural, give location) <u>104 Calhoun Street</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>CATHERINE</u> b. (Middle) <u>APOLLONIA</u> c. (Last) <u>MOYLAN</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>March 21, 1959</u>
---	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>10 Jan 1894</u>	9. AGE (In years last birthday) <u>65</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>City Clerk</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>City Government</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Chillicothe, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
---	--	---	---

13a. FATHER'S NAME <u>Edward Martin</u>	13b. MOTHER'S MAIDEN NAME <u>Rose Feeney</u>	14. NAME OF HUSBAND OR WIFE <u>Charles Henry Moylan</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'S SIGNATURE OR NAME <u>Mrs. Joseph Kinsella; Chillicothe, Mo</u>	ADDRESS _____
--	-------------------------------------	--	---------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>acute coronary occlusion</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
------------------------------	--	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4201</u>
--	--	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
---	--	----------------------------------

22. I hereby certify that I attended the deceased from 3-21, 1959, to 3-21, 1959, that I last saw the deceased alive on 3-21, 1959, and that death occurred at 5:30 pm, from the causes and on the date stated above.

23a. SIGNATURE <u>Joseph F. Gale M.D.</u> (Degree or title)	23b. ADDRESS <u>Chillicothe Mo</u>	23c. DATE SIGNED <u>3-23-59</u>
---	------------------------------------	---------------------------------

24a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3-24-59</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Catholic</u>	24d. LOCATION (City, town, or county) (State) <u>Chillicothe, Missouri</u>
--	--------------------------	--	--

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>3/23/59</u> <u>Francis B. Reed</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman Funeral Home; Chillicothe, Mo</u>	ADDRESS _____
---	--	---------------

1959

NOV 10 1959

June 10, 1960

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

VS JUN 10 1960

Signed *Elton Rosman*.....

Licensed Embalmer No... 4036

P. O. Address Chillicothe..

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.