

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 21 1959 38

59-031432

Registration District No. _____ Primary Registration District No. 3056 Registrar's No. 430

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Randolph</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		c. CITY OR TOWN <u>Moberly</u>	
Length of stay in 1b <u>4 days</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>University Medical Center</u>		d. STREET ADDRESS (If outside, give location) <u>Route One</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Earl</u> Last <u>Canote</u>			4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>1959</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>11-11-31</u>	9. AGE (last birthday) <u>27</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Clifton Hill, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>John Canote</u>		13b. MOTHER'S MAIDEN NAME <u>Lucille Dodd</u>		14. NAME OF HUSBAND OR WIFE <u>Betty Canote</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <u>no</u> , or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>494-38-3287</u>		17. INFORMANT <u>Hospital Chart</u> Address _____	

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>ACUTE POLIOMYELITIS (BULBOSPINAL)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9-10 days</u>
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>ATELECTASIS INVOLVING PORTIONS OF BOTH LUNGS</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____			

20d. INJURY OCCURRED WHILE AT WORK <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>9/9/59</u> to <u>9/12/59</u> and last saw him alive on <u>9/12/59</u> Death occurred at <u>3:45</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>J.S. Sanders</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>Univ. of Mo. Med Center</u>		22c. DATE SIGNED <u>9/12/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Sept-12-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Clifton Hill Cem. Clifton Hill</u>	23d. LOCATION (City, town, or county) <u>Moberly Mo.</u>	(State)

24. FUNERAL DIRECTOR <u>Cater Funeral Home</u>	ADDRESS <u>Moberly Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Sept 12, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed R. M. Carter

Licensed Embalmer No. 4117

P. O. Address Moherly St

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.

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