

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031264

LED VS AUG 19 1960

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 152

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Livingston</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u> Length of stay in 1b <u>18 Mo.</u> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>300 Ninth St.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u> c. CITY OR TOWN <u>Rural</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Jackson Township</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
--	--	---	--

<b>3. NAME OF DECEASED</b> (Type or print) First <u>CHLOE</u> Middle <u>GIBBS</u> Last <u>GIBBS</u>	<b>4. DATE OF DEATH</b> Month <u>Aug.</u> Day <u>14</u> Year <u>1960</u>
---	--

<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>8/2/77</u>	<b>9. AGE (last birthday)</b> <u>83</u>	<b>IF UNDER 1 YEAR</b> Months <u>    </u> Days <u>    </u>	<b>IF UNDER 24 HR</b> Hours <u>    </u> Min. <u>    </u>
-----------------------------	--------------------------------------	---	---------------------------------------	---	---	---

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>Livingston Co., Mo.</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>
---	--	--	--

<b>13a. FATHER'S NAME</b> <u>William Sterling</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Isabelle Nave</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>Horace (Deceased)</u>
---	---	---

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	<b>16. SOCIAL SECURITY NO.</b> <u>none</u>	<b>17. INFORMANT</b> Address <u>Mrs. Horace Conant Fisher, Ill.</u>
---	--	---

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>DUE TO (b)</b> <u>Cerebral Hemorrhage</u> <b>DUE TO (c)</b> <u>Generalized Arteriosclerosis</u>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 days</u>  <u>4 yrs.</u>  <u>10 yrs.</u>
--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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
---	--

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
---	---	---	--	---

<b>20c. TIME OF INJURY</b> Hour <u>    </u> a.m. <u>    </u> p.m.	Month, Day, Year <u>    </u>
---	------------------------------

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	COUNTY STATE
--	---	-------------------------------------	--------------

21. I attended the deceased from May 10 - 1949 to 8-14-60 and last saw her <sup>him</sup> alive on 8-13-60  
 Death occurred at 5:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>R. W. Matheny M.D.</u>	<b>22b. ADDRESS</b> <u>Chillicothe, Missouri</u>	<b>22c. DATE SIGNED</b> <u>8/15/60</u>
---	--	--

<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>8/17/60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Pleasant Cem.</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Livingston Co., Mo.</u>
--	---------------------------------	--	---

<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Ronald Gordon, Chillicothe, Mo.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>Aug. 15, 1960</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Annalee Taylor</u>
--	--	--

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Richard W Banda

Licensed Embalmer No. 486

P. O. Address Chillicothe

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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.