

FILED NOV 8 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 32606

BIRTH NO. 63293-50 REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 276

104

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

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Boone</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u> c. LENGTH OF STAY (In this place) <u>2 Days</u> d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Boone County Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u> d. STREET ADDRESS (If rural, give location) <u>208 Jewel Ave.</u>	
<b>3. NAME OF DECEASED</b> a. (First) <u>ARLLIE</u> b. (Middle) <u>DANNY</u> c. (Last) <u>SHETTLEWORTH</u> (Type or Print)			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Nov. 3, 1950</u>
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Nov. 1, 1950</u>
<b>9. AGE</b> (In years last birthday) <u>0</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)	<b>11. BIRTHPLACE</b> (State or foreign country) <u>Columbia, Mo.</u>
<b>10a. USUAL OCCUPATION</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>
<b>13a. FATHER'S NAME</b> <u>Arllie Allen Shettleworth</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Mary McMasters</u>	<b>14. NAME OF HUSBAND OR WIFE</b> _____
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> ADDRESS <u>A.A. Shettleworth, Columbia, Mo.</u>
<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)		<b>MEDICAL CERTIFICATION</b>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Intra cranial Remonhage</u>	
		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 days</u>	
		<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	
		DUE TO (b) _____ DUE TO (c) _____	
		<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min)	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from <u>Nov 1, 1950</u>, to <u>Nov 3, 1950</u>, that I last saw the deceased alive on <u>Nov 3, 1950</u>, and that death occurred at <u>4 P.M.</u>, from the causes and on the date stated above.</b>			
<b>23a. SIGNATURE</b> <u>Helen E. Yeager</u> (Degree or title) <u>MD</u>		<b>23b. ADDRESS</b> <u>909 University, Columbia, Mo.</u>	<b>23c. DATE SIGNED</b> <u>Nov 4, 1950</u>
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>24b. DATE</b> <u>Nov. 6, 1950</u>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>Columbia Centery</u>	<b>24d. LOCATION</b> (City, town, or county) (State) <u>Columbia, Mo.</u>
<b>DATE REC'D BY LOCAL REG.</b> <u>Nov. 4 1950</u>	<b>REGISTRAR'S SIGNATURE</b> <u>Mrs. R.E. Palmer</u>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>Paran Funeral Service, Columbia Mo.</u>	

RECEIVED 11-6-50

DISTRICT HEALTH OFFICE No. 3

District File Number \_\_\_\_\_

Date Filed 11-6-50

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

*Tom M. Harg*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. *4002*

P. O. Address *Columbia Mo.*

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 this body is not embalmed, fact should be so stated above.