

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 14 1951

BIRTH NO. _____ REG. DIST. NO. **179** PRIMARY REG. DIST. NO. **5669** Registrar's No. **27**

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Lincoln | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lincoln | |
| b. CITY (If outside corporate limits, write RURAL and give township) Rural Hawkpoint | | c. CITY (If outside corporate limits, write RURAL and give township) Rural Hawkpoint | |
| c. LENGTH OF STAY (in this place) 9 yr. | | d. STREET ADDRESS (If rural, give location) 0570 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | | |

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|--|-------------------------------|--|--|--|---|
| 3. NAME OF DECEASED a. (First) GEORGE b. (Middle) IRWIN c. (Last) SHOULTS | | | 4. DATE OF DEATH (Month) (Day) (Year) June 28 1951 | | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH (Month) (Day) (Year) May 15 1942 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years) (last birthday) 9 (Months) 1 (Days) 3 | | 11. BIRTHPLACE (State or foreign country) Missouri |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |

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|---|---|-----------------------------|
| 13a. FATHER'S NAME Chris Shoults | 13b. MOTHER'S MAIDEN NAME Florence Zimmalt | 14. NAME OF HUSBAND OR WIFE |
|---|---|-----------------------------|

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|--|-------------------------------------|--|-------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | 16. SOCIAL SECURITY NO. none | 17. INFORMANT'S SIGNATURE OR NAME Chris Shoults Silex | ADDRESS ms |
|--|-------------------------------------|--|-------------------|

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| 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, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 4 years |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hodgkin's Disease | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) none | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none | | 201X | |

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|------------------------------------|--|--|
| 19a. DATE OF OPERATION none | 19b. MAJOR FINDINGS OF OPERATION none | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) none | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) none |
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| | | |
|---|--|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> none | 21f. HOW DID INJURY OCCUR? none |
|---|--|--|

22. I hereby certify that I attended the deceased from **February 1951**, to **June 28 1951**, that I last saw the deceased alive on **June 26, 1951**, and that death occurred at **2:00 P.M.**, from the causes and on the date stated above.

| | | |
|---|---|-------------------------------------|
| 22a. SIGNATURE Don Z. Randall M.D. (Degree or title) | 23b. ADDRESS 207 N. 5th St. Charles, Mo. | 23c. DATE SIGNED July 2 1951 |
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|---|--------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 6-30-51 | 24c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery Lincoln County Mo | 24d. LOCATION (City, town, or county) (State) ms |
|---|--------------------------|---|---|

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|---|---|---|------------------------|
| DATE REC'D BY LOCAL REG. July 7-1951 | REGISTRAR'S SIGNATURE Emma R. Riddle | 25. FUNERAL DIRECTOR'S SIGNATURE Wayne McEay | ADDRESS Troy Mo |
|---|---|---|------------------------|

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

File No. _____
DISTRICT HEALTH OFFICE No. 4

JUL - 9 1951

RECEIVED

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
Student Embalmer

Signed Wayne McCoy

Licensed Embalmer No. 3586

P. O. Address Troy 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.