

STANDARD CERTIFICATE OF DEATH

26044

State File No.

FILED SEP 12 1951

0013
0

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

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 242

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Lingo Township</u> <u>0610</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>K.C.O.S. Hospital</u>		d. STREET ADDRESS (If rural, give location) -----	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mattie</u> b. (Middle) <u>Genora</u> c. (Last) <u>Shatto</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sep. 5, 1951</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>April 13, 1878</u>
9. AGE (In years last birthday) <u>73</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Browning, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Lon Jacobs</u>	
13b. MOTHER'S MAIDEN NAME <u>Alice-----</u>		14. NAME OF HUSBAND OR WIFE <u>James Shatto</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>No.</u>	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John Shatto, New Cambria, Mo.</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Paralytic Ileus</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Fracture (intertrochanteric of right hip.</u> DUE TO (c) <u>16 days.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>senility-cirrhosis of liver</u>	
18b. INTERVAL BETWEEN ONSET AND DEATH <u>60 hrs</u>		19a. DATE OF OPERATION <u>Sept 5</u>	
19b. MAJOR FINDINGS OF OPERATION <u>Paralytic ileus</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
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 <u>8-23</u> , 19 <u>51</u> , to <u>9-5</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Sept 5</u> , 19 <u>51</u> , and that death occurred at <u>1:20 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>D.O.</u>		23b. ADDRESS <u>Kirksville Mo</u>	
23c. DATE SIGNED <u>9-6-51</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>Sep. 7, 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Dodson Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>New Cambria, Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>[Signature] Kirksville Mo</u>	
DATE REC'D BY LOCAL REG. <u>9-8-51</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>	

Date Received: SEP 11 1951
DISTRICT HEALTH OFFICE #2
District File Number 9-57-1595-
Date Filed: SEP 11 1951

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 *Donald L. Roberts*

Licensed Embalmer No: *4722*

P. O. Address *Ficksville Md*

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.