

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15591**

FILED MAY 26 1952

BIRTH NO. _____ REG. DIST. NO. **38** PRIMARY REG. DIST. NO. **3006** Registrar's No. **136**

1. PLACE OF DEATH a. COUNTY BOONE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY BOONE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN COLUMBIA		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN COLUMBIA	
c. LENGTH OF STAY (in this place) 5 yrs		0105	
d. FULL NAME OF HOSPITAL OR INSTITUTION 417 North 9th St		d. STREET ADDRESS (If rural, give location) 417 N 9th St	

3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) ALEXANDER c. (Last) SHORTER	4. DATE OF DEATH (Month) (Day) (Year) MAY 20, 1952
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH Sept 28 1875	9. AGE (In years last birthday) 76	if UNDER 1 YEAR Months 7 Days 22	if UNDER 1 MRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER DECORATOR	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) VIRGINIA	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME DONT KNOW	13b. MOTHER'S MAIDEN NAME DONT KNOW	14. NAME OF HUSBAND OR WIFE BELLE SHORTER
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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 NO	16. SOCIAL SECURITY NO. 201 03 8794	17. INFORMANT'S SIGNATURE OR NAME C.H. LAWSON ADDRESS 417 N. 9 Columbia
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		2 weeks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis & hypertension DUE TO (c) Prostatic Hypertrophy		331X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) 20	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **May 8, 1952**, to **May 20, 1952**, that I last saw the deceased alive on **May 19, 1952**, and that death occurred at **A.M.** m., from the causes and on the date stated above.

23a. SIGNATURE Samuel D. Lambert (Degree or title)	23b. ADDRESS Columbia, Mo	23c. DATE SIGNED May 21, 1952
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE MAY 21-52	24c. NAME OF CEMETERY OR CREMATORY MAMORIAL PARK	24d. LOCATION (City, town, or county) (State) COLUMBIA MO
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DATE REC'D BY LOCAL REG. May 21 1952	REGISTRAR'S SIGNATURE Mrs. R.E. Palmer	31	25. FUNERAL DIRECTOR'S SIGNATURE A. Sweet ADDRESS Columbia, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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OCT 3 1952

JAN 11 1958

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, ~~and~~

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Erman H. Sprinkle*

Licensed Embalmer No. *4013*

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.