

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUL 25 1955

State File No. **23046**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **201** PRIMARY REG. DIST. NO. **3048** Registrar's No. **188**

1. PLACE OF DEATH a. COUNTY <b>Nodaway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Gentry</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>TOWN Maryville</b>		c. LENGTH OF STAY (in this place) <b>27 days</b>	c. CITY OR TOWN <b>Albany</b>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>St. Francis Hospital</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
f. STREET ADDRESS (If rural, give location) <b>0380</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>John</b>	b. (Middle) <b>Lester</b>	c. (Last) <b>Shutters</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>July 19 1955</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>8-28-89</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Month <b>10</b> Days <b>21</b>	IF UNDER 24 HRS. Hour <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postal Clerk</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Postoffice</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Scott County, Indiana</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>Daniel Shutters</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Alsop</b>	14. NAME OF HUSBAND OR WIFE <b>Cora McFall Shutters</b>
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Morris Shutters</b>	ADDRESS <b>Maryville, Mo.</b>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebro Vascula Accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cerebral Arteriosclerosis</b>		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>331X</b>			

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)	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) (Min.)	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 **June 22, 1955**, to **July 19, 1955**, that I last saw the deceased alive on **July 18, 1955**, and that death occurred at **1:30 A.M.** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>[Signature]</b>	23b. ADDRESS <b>[Address]</b>	23c. DATE SIGNED <b>7-20-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>7-21-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Grandview Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>Albany, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>7-23 55</b>	REGISTRAR'S SIGNATURE <b>Bess Bolt</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>	ADDRESS <b>Albany Mo</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

AUG 2 1954

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 me..... Student Embalmer No..... working under my personal supervision..

Student..... Signature of Student Embalmer

Signed *Clifford Brooks*.....

Licensed Embalmer No. 3329

P. O. Address Albany, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.