

FILED FEB 27 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4505

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>137</u>		PRIMARY REG. DIST. NO. <u>3027</u>		Registrar's No. <u>112</u>	
1. PLACE OF DEATH a. COUNTY <u>Henry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u>			
b. CITY OR TOWN <u>Clinton</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>Clinton</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Clinton General Hosp.</u>				e. STREET ADDRESS (If rural, give location) <u>312 East Ohio</u> 04 0			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ethel</u>			b. (Middle) <u>O</u>		c. (Last) <u>Paague</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2-17-1956</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>1-19-1883</u>		9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work during most of working life (even if retired)) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Clinton Mo</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>James Shobe</u>		13b. MOTHER'S MAIDEN NAME <u>Rebecca Thurman</u>		14. NAME OF HUSBAND OR WIFE <u>William Paague</u>			
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 ADDRESS <u>William Paague Clinton 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Pyelonephritis</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>Unknown</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6.000	
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) _____		21f. HOW DID INJURY OCCUR? _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>2-1</u> , 19 <u>56</u> , to <u>2-17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-17</u> , 19 <u>56</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>W.D. Bradshaw, MD</u> (Degree or title) _____		23b. ADDRESS <u>Clinton, Mo</u>		23c. DATE SIGNED <u>2-19-56</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2-19-1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Englewood cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Clinton Mo</u>	
DATE REC'D BY LOCAL REG. <u>2-19-56</u>		REGISTRAR'S SIGNATURE <u>Mildred Bigoni</u> 521-		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Sickman Dunning Clinton Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....  
Signature of Student Embalmer

Signed..... *Robert L. Dunnington*

Licensed Embalmer No. *4710*

P. O. Address *Clinch*

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.