

Health, Welfare and Public Service

300 -56

Use only black ink or ribbon typewrite if possible. Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33425
STATE FILE NUMBER

FILED OCT 22 1956

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 95

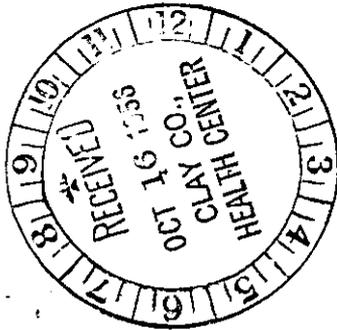
1. PLACE OF DEATH a. COUNTY Clay		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Excelsior Springs, Mo. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City, Mo. 3036 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Veterans Administration Hospital Length of stay in lb -6 mos 18		d. STREET ADDRESS (If outside, give location) 439 Tracy Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALLEN First R Middle SHRIVER Last days		4. DATE OF DEATH Sept. 26, 1956 Month Sept. Day 26 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1905
9. AGE (In years last birthday) 51		IF UNDER 1 YEAR Months 51 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Common laborer		10b. KIND OF BUSINESS OR INDUSTRY Common laborer	11. BIRTHPLACE (City and state or country) Kansas City, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Daniel B. Shriver	
14. MOTHER'S MAIDEN NAME Nancy M. McCarthy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII	
16. SOCIAL SECURITY NO. 493121892		17. INFORMANT VA Hospital records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculosis, pulmonary, chronic, far advanced, active, with tuberculous empyema, left & pleuro-cutaneous sinus Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchiectasis			INTERVAL BETWEEN ONSET AND DEATH Several years
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			002x
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -- --		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) -- --	20f. CITY, TOWN, OR LOCATION -- --	COUNTY -- --	STATE -- --
21. VA attended the deceased from March 9, 1956 to Sept. 26, 1956 and at the VA hospital at Excelsior Springs, Mo. Death occurred at 8:30 A. M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) F. B. Mantell, M.D., Acting Pathologist		22b. ADDRESS Excelsior Springs, Mo.	22c. DATE SIGNED 9-28-56
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-1-56	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Leavenworth, Kansas
24. FUNERAL DIRECTOR Prichard Funeral Home, Inc. Excelsior Springs, Missouri (Licensed Embalmer's Statement on Reverse Side)		25. DATE RECD. BY LOCAL REG. 10-10-56	26. REGISTRAR'S SIGNATURE Caroline Hutchings

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

6-22-56

32-0



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 *Lindell Jarman*.....

Licensed Embalmer No. *45*

Excelsior Spring
P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.