

Health, Welfare, Public Service
 300
 9-56
 ALL diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
 MEDICAL CERTIFICATION
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED APR 8 - 1957

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

7996

STATE FILE NUMBER

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 22

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, give TOWNSHIP OR TOWN) <u>Excelsior Springs</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Carrollton, Mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Excelsior Springs Hosp. 3da.</u> Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>215 Ford St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Venita</u> Middle <u></u> Last <u>Newkam</u>			4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1957</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 7, 1923</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years last birthday) <u>33</u>
11. BIRTHPLACE (City and state or country) <u>Monticello, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Fredrick Shover</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Houston</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>44-0244-744</u>	
17. INFORMANT <u>Charles Newkam, Jr.</u>		Address <u>Carrollton, Mo</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ventricular fibrillation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Valvular heart disease</u> DUE TO (c) <u>Rheumatic fever</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5'</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>414x</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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 <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>			
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. I attended the deceased from <u>Sept 1947</u> to <u>Mar. 1957</u> and last saw her/him alive on <u>18 Mar. 1957</u> Death occurred at <u>2:23 p.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>George E. Sanders M.D.</u>		22b. ADDRESS <u>Excelsior Springs, Mo.</u>	
22c. DATE SIGNED <u>3-18-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>3/18/57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Carrollton, Mo.</u>	
24. FUNERAL DIRECTOR <u>Marshall Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>3/20/57</u>	
ADDRESS <u>Carrollton</u>		26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>	

(Licensed Embolmer's Statement on Reverse Side)



APR 15 1957

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.....
Ann Moulton

Licensed Embalmer No. 44

P. O. Address *Carroll*

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.