

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12227**

FILED APR 22 1957

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **409**

4
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). —a.—STATE Missouri b. COUNTY Buchanan	
b. CITY OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
d. FULL NAME OF HOSPITAL OR INSTITUTION Georgetown Nursing Home		e. STREET ADDRESS (If rural, give location) 3404 1/2 Burnside Avenue 0117	
c. LENGTH OF STAY (in this place) 10 yrs		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) TINA		b. (Middle) ELIZABETH	
c. (Last) SHAMPNOI		4. DATE OF DEATH (Month) (Day) (Year) APRIL 2, 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept 22, 1877
9. AGE (In years last birthday) 79		10. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (City and State or Foreign Country) Cabool, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		13a. FATHER'S NAME Alfred Lamberd	
13b. MOTHER'S MAIDEN NAME Hariett (unknown)		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Clyde M. Champnoi, St. Joseph, Mo.		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH week	
*This does not mean the mode of dying, such as heart failure, atherosclerosis, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
DUE TO (b) Hypertension		years	
DUE TO (c) General arteriosclerosis		years	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from March 26 1957 , to Apr 2, 1957 , that I last saw the deceased alive on 3/26, 1957 , and that death occurred at 12:45A m., from the causes and on the date stated above.	
23a. SIGNATURE McGuire MD		23b. ADDRESS St. Joseph, Missouri	
23c. DATE SIGNED 4/2/57		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Apr 4, 1957		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	
24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Stamey Funeral Home, St. Joseph, Mo.	
DATE REC'D BY LOCAL REG. April 17, 1957		REGISTRAR'S SIGNATURE Kathleen M. Allison	

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..... *Charles E. Bennett*

Licensed Embalmer No. *11677*.....

P. O. Address *St. Joseph 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.