

Health, Welfare, Public Service  
 300  
 1-56  
 Director, coroner, etc. must use only standard maintenance forms to report. No symptoms will be listed. All diseases in Part I must be casually related. Coroner can certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUL 19 1957

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

25339

STATE FILE NUMBER

Registration District No. 200 Primary Registration District No. 5725 Registrar's No. 102

1. PLACE OF DEATH a. COUNTY <b>Macon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Platte</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hudson</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>Dearborn</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <b>Missouri State Sanatorium</b> Length of stay in lb <b>3 mo, 22 days</b>		d. STREET ADDRESS (If outside, give location) <b>0830</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John R Shikles</b> First Middle Last		4. DATE OF DEATH <b>June 29 1957</b> Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 21 1878</b>
9. AGE <b>83</b> years last birthday		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Veterinarian</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>East Haven worth Mo</b>
13. FATHER'S NAME <b>James Shikles</b>		14. MOTHER'S MAIDEN NAME <b>Edna Rapp</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>UNK</b>		16. SOCIAL SECURITY NO. <b>UNK</b>	
17. INFORMANT <b>Hospital Records</b>		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) <b>Inanition and debilitation</b> <b>carcinomatosis involving</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>biliary function</b> DUE TO (c) <b>Primary carcinoma of Liver</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arterio sclerosis brain syndrome 1551</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 .a. m. .p. m. Hour Month, Day, Year			
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 <b>Mar 7 1957</b> to <b>June 29 1957</b> and last saw him alive <b>June 29 1957</b> Death occurred at <b>8:10 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>H. P. Hoyle W.D.</b>		22b. ADDRESS <b>2 Macon Mo</b>	22c. DATE SIGNED <b>June 29 57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 2 57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dearborn Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Dearborne Mo.</b>
24. FUNERAL DIRECTOR <b>C. W. Adtranc</b> ADDRESS <b>Dearborne Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>6/29/57</b>	26. REGISTRAR'S SIGNATURE <b>Cuth M. Sreely</b>

(Licensed Embalmer's Statement on Reverse Side)

APR 9 1959

SEP 6 1958

FILED  
7 18 57

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 L. Hite* .....

Licensed Embalmer No. *45*

P. O. Address *Macon*

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.