FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

'57 027578
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 892

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Mo. Methodist Hospital — Length of stay in 1b: 55 years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN St. Joseph — Inside Limits Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location) Route 6 — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First EDDY Middle H Last SHALINE
4. DATE OF DEATH Month Aug. Day 8 Year 1957
5. SEX Male
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Feb. 24, 1880
9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Grocer
10b. KIND OF BUSINESS OR INDUSTRY Retail Foods
11. BIRTHPLACE (City and state or country) Unknown Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME David Shaline
13b. MOTHER'S MAIDEN NAME Annie Harlan
14. NAME OF HUSBAND OR WIFE Bertha Shaline
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 498-24-9959
17. INFORMANT Bertha Shaline Address Rt. 6, St. Joseph, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) with Congestive Failure — Unk
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4 200
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 July 20 1954, to Aug 7, 1957 and last saw him alive on Aug 7, 1957
Death occurred at 8:13 a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Martin H. Christ MD (Degree or title)
22b. ADDRESS 6106 King Hill Ave
22c. DATE SIGNED 8-9-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Aug. 10, 57
23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery
23d. LOCATION (City, town, or county) St. Joseph, Mo. (State)

24. FUNERAL DIRECTOR Clark Funeral Home ADDRESS St. Joseph, Mo
25. DATE RECD. BY LOCAL REG. Aug. 16, 1957
26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton
(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

## 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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.