

Health,
& Welfare,
Public
Service

FILED OCT 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER
36132
4529

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4529

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY Jackson		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 Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center		Length of stay in lb 47 yrs.	d. STREET ADDRESS (If outside, give location) 1020 Penn Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Sarah Middle Dorcas Last Shackelford			4. DATE OF DEATH Month Sept. Day 24 Year 1957		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-13-78	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS	10b. KIND OF BUSINESS OR INDUSTRY CARPENT. IND.	11. BIRTHPLACE (City and state or country) RAY COUNTY, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME ANDREW J. SHACKELFORD	13b. MOTHER'S MAIDEN NAME THEODOSIA WETHERHOLT	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 487-05-2947	17. INFORMANT ETHEL SHACKELFORD - HARDING, Mo.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of Meiglit middle cerebral Art.		INTERVAL BETWEEN ONSET AND DEATH 8 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Myocardial Infarction, Chronic		1 year
	DUE TO (c) Aortic Valve Uerroucity, Stenosis.		1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4211		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from Nov 24, 1950 to Sept 24, 1957 and last saw her alive on Sept 24, 1957 Death occurred at 310 P m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE J.S. Hoffman (Degree or title) MD	22b. ADDRESS 330 Professional Bldg	22c. DATE SIGNED 9-26-57
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-26-57	23c. NAME OF CEMETERY OR CREMATORY Lansdown Cemetery	23d. LOCATION (City, town, or county) (State) Ray County Mo.
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24. FUNERAL DIRECTOR August Buchdick ADDRESS Harding, Mo.	25. DATE RECD. BY LOCAL REG. 9-30-57	26. REGISTRAR'S SIGNATURE Neva Minshall
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

J.S. Hoffman



OCT 22 1957

DEC 4 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 *August Boecharding*

Licensed Embalmer No. *4678*

P. O. Address *Herbin, 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.