

Dr. Francka  
**FILED FEB 27 1958**

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

**58-006463**

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 55

300  
-57

1. PLACE OF DEATH a. COUNTY <u>Marion</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Hannibal</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>715 State</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>715 State</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Duffield</u> Last <u>Shuck</u>			4. DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/14/1893</u>	9. AGE (In years last birthday) <u>65</u>	10. FUNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Halls, Boone County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>John H. Shuck</u>		13b. MOTHER'S MAIDEN NAME <u>Mecie Clark</u>		14. NAME OF HUSBAND OR WIFE <u>Olevia Shuck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>486-14-1568</u>	17. INFORMANT Address <u>Mrs. Gertrude Tillitt, Hannibal, 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>Coronary Thrombosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>few min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary Insufficiency</u>					<u>3</u>
DUE TO (c) <u>A.S.H.D.</u>					<u>7</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>					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 Hour <u>          </u> Month, Day, Year a.m. <u>          </u> p.m. <u>          </u>					
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	
21. I attended the deceased from <u>June - 57</u> to <u>2-18-58</u> and last saw <sup>her</sup> alive on <u>2-10-58</u> Death occurred at <u>3:15 A. M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Dr. Francka md</u> (Degree or title)			22b. ADDRESS <u>Hannibal, Mo.</u>		22c. DATE SIGNED <u>2-19-58</u>
23a. BURIAL, CREMATION, REBOYAL (Specify) <u>Burial</u>		23b. DATE <u>2/21/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hannibal, Mo.</u>
24. FUNERAL DIRECTOR <u>H.M.O'Donnell, Hannibal, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2/19/58</u>		26. REGISTRAR'S SIGNATURE <u>Dr. M. J. Fisher</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

**RECEIVED** FEB 25 1958  
**MARION CO. HEALTH DEPT.**  
**DATE FILED** FEB 25 1958

**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 J. M. O'Donnell .....

Licensed Embalmer No. 3889 .....

P. O. Address Hannibal, 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.