

Birth, Marriage, Divorce, Public Service

Dr. Johnson  
FILED MAR 31 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-009597  
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 324

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Springfield</b> 0396 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hosp.</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>637 W. Scott</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>FRED</b> Middle <b>SHANKS</b> Last <b>SHANKS</b>			4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>1958</b>		
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5. SEX <b>Male</b> 0	6. COLOR OR RACE <b>White</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>MAY 26 1883</b>	9. AGE (In years at birthday) <b>74</b>	10. UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Sheet Metal Worker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Frisco R. R.</b>	11. BIRTHPLACE (City and state or country) <b>Springfield, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Clement Shanks</b>	13b. MOTHER'S MAIDEN NAME <b>Mable White</b>	14. NAME OF HUSBAND OR WIFE <b>Belle Shanks (Dec.)</b>
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Charles E. Shanks</b>	Address <b>Springfield, Mo.</b>
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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) <b>Cerebrovascular accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Benign Hypertrophy of prostate, prostat</b>		<b>1-2 yrs</b>
	DUE TO (c) <b>carcinoma of bladder, prostat</b>		<b>6 mos?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>carcinoma of kidney, left.</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.) <b>1810</b>	
20c. TIME OF INJURY Hour <b>2:10</b> Month, Day, Year <b>11. 27. 57</b> a.m. <b>p.m.</b>		
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 <b>Springfield</b> COUNTY <b>Greene</b> STATE <b>Missouri</b>

21. I attended the deceased from **12-11-57**, to **3-25-58** and last saw him alive on **3-25-58**  
Death occurred at **2:10 p.m.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>William F. Johnson, M.D.</b>	(Degree or title)	22b. ADDRESS <b>211 Professional Bldg. Springfield, Missouri</b>	22c. DATE SIGNED <b>3-26-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>March 28, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maple Park</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Mo.</b>
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24. FUNERAL DIRECTOR <b>H.H. Lohmeyer</b>	ADDRESS <b>Springfield, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>3-26-58</b>	26. REGISTRAR'S SIGNATURE <b>Effie G. Melton</b>
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USE ONLY BLACK INK. CORRECTED AND HAVE INITIALS IN RED. MEDICAL CERTIFICATE FOR 157

All diseases in Part I must be causally related.

APR 10 1958

APR 1 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ~~was~~ <sup>not</sup> embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

*cut*

Signed *R. L. McCarroll* .....

Licensed Embalmer No. *2727* .....

P. O. Address *Springfield* .....

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.