

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038623
STATE FILE NUMBER

FILED OCT 28 1958 Registration District No. 354 Primary Registration District No. 4519 Registrar's No. 72

1. PLACE OF DEATH a. COUNTY Texas		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Texas	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cabool		c. CITY OR TOWN Cabool	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) 1670 Codar St.	
3. NAME OF DECEASED (Type or print) First Addie Middle Irene Last Shaver		4. DATE OF DEATH Month Oct. Day 17, Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Hartville, Mo. 0
13a. FATHER'S NAME Daniel W. Shaver		13b. MOTHER'S MAIDEN NAME Paulina J. Martin	12. CITIZEN OF WHAT COUNTRY? USA
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. none	17. INFORMANT Address Phoobe Stogsdill, Cabool, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Cerebral arteriosclerosis DUE TO (c) 331X			INTERVAL BETWEEN ONSET AND DEATH 30 min. 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 _____ a.m. _____ p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		20f. COUNTY STATE	
21. I attended the deceased from June 1957 to October 58 and last saw her alive on Oct. 17, 1958 Death occurred at 8:15 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J. L. Spears MD 0		22b. ADDRESS Cabool, Mo	
22c. DATE SIGNED 10/21/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-20-58	
23c. NAME OF CEMETERY OR CREMATORY Cabool Cemetery		23d. LOCATION (City, town, or county) (State) Cabool, Missouri	
24. FUNERAL DIRECTOR ADDRESS Elliott-Gentry, Cabool, Mo.		25. DATE RECD. BY LOCAL REG. 10-21-58	
26. REGISTRAR'S SIGNATURE Faynell Cunningham			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 James L. Henty
Licensed Embalmer No. 47
P. O. Address Calool

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.