ealth, Welfare ublic ervice

300
-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005003
STATE FILE NUMBER

FILED FEB 25 1959 Registration District No. 100 Primary Registration District No. _____ Registrar's No. 4

1. PLACE OF DEATH a. COUNTY Dent b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Salem — Inside Limits Yes [X] No [ ] c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Highway 19 So. — Length of stay in Ib 7 yrs	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dent c. CITY OR TOWN Salem — Inside Limits Yes [X] No [ ] d. STREET ADDRESS (If outside, give location) Highway 19 So — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First David Middle Columbus Last Shults
4. DATE OF DEATH: Month Feb Day 18 Year 1959
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Feb 16 1888
9. AGE (In years last birthday): 71 — 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): farming
10b. KIND OF BUSINESS OR INDUSTRY: general
11. BIRTHPLACE (City and state or country): Dent Co Mo
12. CITIZEN OF WHAT COUNTRY? U S A
13a. FATHER'S NAME: Jodie Shults
13b. MOTHER'S MAIDEN NAME: Mary Hewitt
14. NAME OF HUSBAND OR WIFE: Cora McNeill
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) No (If yes, give year or dates of service) X
16. SOCIAL SECURITY NO.: 512 03 8177
17. INFORMANT: Cora Shults Address: Salem Mo

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: One week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis
DUE TO (c) Generalized Arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Severe Malnutrition + Emphysema 331X
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 June 1955 to Feb 18 1959 and last saw her/him alive on 2/16/59
Death occurred at 2/18/59 p m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE B. J. Ross, MD (Degree or title)
22b. ADDRESS Salem, Mo.
22c. DATE SIGNED 2/23/59

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 2-20-59
23c. NAME OF CEMETERY OR CREMATORY: Cedar Grove Cem
23d. LOCATION (City, town, or county) (State): Salem Mo
24. FUNERAL DIRECTOR: Spencer Funeral Home Inc ADDRESS
25. DATE RECD. BY LOCAL REG.: 2/23/59
26. REGISTRAR'S SIGNATURE: M. M. Hark, M.D. by A.M.

(Licensed Embalmer's Statement on Reverse Side)

Doctor, Coroner, etc. must use only practical nomenclature in Item 18 to describe the symptoms
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.