

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008067

STATE FILE NUMBER

Health,
Welfare
Public
Service

FILED MAR 16 1959 Registration District No. 925 Primary Registration District No. 4488 Registrar's No. 18

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <i>Schuyler</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Prentiss</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Kansas City</i>		300.6 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Nursing Home</i>				Length of stay in 1b <i>3 mo</i>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Amy</i> Middle <i>MAY</i> Last <i>SHAW</i>				4. DATE OF DEATH Month <i>Mar</i> Day <i>5</i> Year <i>'59</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>July 17 1896</i>	9. AGE (In years last birthday) <i>62</i>	IF UNDER 1 YEAR Months <i>6</i> Days <i>2</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stenographer</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad (U.P.)</i>		11. BIRTHPLACE (City and state or country) <i>Scotland, Co. Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Matthew Shaw</i>				14. MOTHER'S MAIDEN NAME <i>Lucinda Evalina Kerr</i>			
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. <i>491-22-2294</i>		17. INFORMANT <i>Clarence W. Shaw</i>		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Medullary Failure</i>							INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) <i>Inanition</i> <i>5 mo.</i>
DUE TO (c) <i>Parkinson's Disease</i> <i>8 yrs.</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pernicious Anemia</i>							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 <i></i> Month <i></i> Day <i></i> Year <i></i> a. m. <i></i> p. m. <i></i>							
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		COUNTY	STATE
21. I attended the deceased from <i>8/13/50</i> to <i>3/5/59</i> and last saw her ^{her} _{him} alive on <i>3/3/59</i> Death occurred at <i>1:55 p. m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.							
22. SIGNATURE <i>Edward M. Roberts M.D.</i>				22a. ADDRESS <i>Queen City Mo.</i>		22c. DATE SIGNED <i>3/6/59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)		(State)
<i>Removal</i>	<i>Mar. 9-'59</i>	<i>Prairie View Cemetery near Memphis Missouri</i>			<i>Queen City Mo.</i>		<i>Mo.</i>
24. FUNERAL DIRECTOR <i>Dorley Fun Home</i>			ADDRESS <i>Queen City Mo.</i>	25. DATE RECD. BY LOCAL REG <i>3-9-59</i>	26. REGISTRAR'S SIGNATURE <i>Edw. R. J. Baker</i>		

(Licensed Embalmer's Statement on Reverse Side)

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 *Jack H. Farley*.....

Licensed Embalmer No..... 40

P. O. Address .. *Queen City*

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.