

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016555  
STATE FILE NUMBER

FILED APR 23 1959 Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 58

300  
1-57

Health, Welfare, Public Service  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be traced.  
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Vernon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Nevada</u> <sup>1083</sup> 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>State Hospital</u> Length of stay in 1b <u>3 mo 13 days</u>		d. STREET ADDRESS (If outside, give location) <u>120 South Park</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MELVIN - SHULTS</u>			4. DATE OF DEATH Month Day Year <u>April 10, 1959</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 26, 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (In years last birthday) <u>73</u> IF UNDER 1 YEAR Months <u>9</u> Days <u>29</u> Hours <u>-</u> Min. <u>-</u>
11. BIRTHPLACE (City and state or country) <u>Vernon County Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Wm Shults</u>		13b. MOTHER'S MAIDEN NAME <u>Elsie Raines</u>	14. NAME OF HUSBAND OR WIFE <u>Rose Morris</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>496-22-2755</u>	17. INFORMANT Address <u>Records State Hosp Nevada 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>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4200</u>
20a. ACCIDENT <input checked="" 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>10</u> Month, Day, Year _____ a.m. _____ p.m.		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>Dec 29, 1958</u> to <u>April 10, 1959</u> and last saw her alive on <u>April 10, 1959</u> Death occurred at <u>6:35 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Paul L Barone M.D.</u>		22b. ADDRESS <u>State Hospital 3 Nevada Mo</u>	22c. DATE SIGNED <u>April 10/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>April 13, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Newton Burial Park</u>	23d. LOCATION (City, town, or county) (State) <u>Nevada Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Ferry Funeral Home Nevada, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-13-1959</u>	26. REGISTRAR'S SIGNATURE <u>Orma E Ferry</u>

Aug 29 1962

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 *L. Stephen Ferry* .....

Licensed Embalmer No. *4960* .....

P. O. Address *Meriden, Conn.* .....

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.