

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017561
STATE FILE NUMBER

JUN 8 1959 Registration District No. 141 Primary Registration District No. 5551 Registrar's No. 68

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWNSHIP <u>West Plains</u>		c. CITY OR TOWNSHIP <u>West Plains</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rte 1</u>		d. STREET ADDRESS (If outside, give location) <u>Rte 1</u>	
Length of stay in lb <u>8 mos</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Angie Louise Shearin</u>			4. DATE OF DEATH Month Day Year <u>6-2-1959</u>		
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-19-1958</u>	9. AGE (In years last birthday) Month Days <u>8 13</u>	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) <u>Infant</u>	10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and state or country) <u>West Plains Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Lay Adams</u>	13b. MOTHER'S MAIDEN NAME <u>Pearl Shearin</u>	14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Pearl Shearin West Plains Mo</u>
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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) <u>accidental suffocation caused by head being caught between mattress & bed post while left alone on bed</u>		INTERVAL BETWEEN ONSET AND DEATH
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) <u>9240 18</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.) <u>rolled away on stomach wedged head between bed post & mattress</u>	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>West Plains</u>	COUNTY <u>Howell</u> STATE <u>MO</u>

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at about 7:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) <u>Lester Lewis Skiffel, Coroner</u>	22b. ADDRESS <u>West Plains Mo</u>	22c. DATE SIGNED <u>6/3/59</u>
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23a. BURIAL (CREMATION, REINTERMENT) (Specify)	23b. DATE <u>6-5-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Aycock</u>	23d. LOCATION (City, town, or county) (State) <u>Tomona Mo</u>
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24. FUNERAL DIRECTOR <u>Robert's West Plains Mo</u>	25. DATE RECD. BY LOCAL REG. <u>6-5-59</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
1-57

790

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. 3487
P. O. Address Ill. at Home

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.