

pt. Health,  
e., & Welfare  
S. Public  
Health Service

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

59-020111  
STATE FILE NUMBER

FILED MAY 19 1959 Registration District No. 337 Primary Registration District No. 6143 Registrar's No. 45

1. PLACE OF DEATH a. COUNTY <u>Shelby</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Iowa</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lentner</u>		c. CITY OR TOWN <u>Davenport</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1-Mile E. Lentner</u>		814 <sup>d</sup> STREET ADDRESS (If outside, give location) <u>715-E. 36 St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>May</u> Last <u>Paasch</u>		4. DATE OF DEATH Month <u>5</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>Female</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>11-22-1915</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	11. BIRTHPLACE (City and state or country) <u>Faith, Illinois</u>
13a. FATHER'S NAME <u>Sam Waller</u>		13b. MOTHER'S MAIDEN NAME <u>Henrietta Ross</u>	14. NAME OF HUSBAND OR WIFE <u>Arnold Rudolph Paasch</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> <u>None</u>		16. SOCIAL SECURITY NO. <u>X</u>	17. INFORMANT Address <u>Iowa</u> <u>Gene Paasch 715 E. 36 St. Davenport</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>Broken neck</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>accident (automobile)</u> DUE TO (c) _____ 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 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>Broken neck at skull</u>	
20c. TIME OF INJURY Hour <u>2</u> a.m. <u>May 11 1959</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. CITY, TOWN, OR LOCATION <u>Lentner</u>	COUNTY <u>Shelby</u> STATE <u>Missouri</u>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Thomas V. Garrison</u> <u>acting coroner Shelby Co. Mo</u>		22b. ADDRESS <u>Shelbina Mo</u>	22c. DATE SIGNED <u>May 11 1959</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5-11-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairmount</u>	23d. LOCATION (City, town, or county) (State) <u>Davenport, Iowa</u>
24. FUNERAL DIRECTOR ADDRESS <u>Barkeley &amp; Davis Shelbina, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>May 11-59</u>	26. REGISTRAR'S SIGNATURE <u>Ada Garrison</u>

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

4190

MAY 8 0 8 AM '63

SEP 4 1963

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 W. Davis* .....

Licensed Embalmer No. *4478*  
P. O. Address *Shelton, CT*

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.