

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024607

FILED VS AUG 11 1959

Registration District No. 93 Primary Registration District No. _____ Registrar's No. 59-60 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Dade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lockwood</u>		Length of stay in lb <u>App. 1 hr.</u>		c. CITY OR TOWN <u>Miller</u>		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>Memorial Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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 <u>Rozella</u> Middle _____ Last <u>Shaffer</u>				4. DATE OF DEATH Month <u>8</u> Day <u>1</u> Year <u>1959</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-11-1873</u>		9. AGE (last birthday) <u>85</u> IF UNDER 1 YEAR IF UNDER 24 HR Months <u>9</u> Days <u>21</u> Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Lawrence Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		
13a. FATHER'S NAME <u>James A. Gibson</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Jane Hunt</u>			14. NAME OF HUSBAND OR WIFE (Dec'd) <u>John Shaffer</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>None</u>		17. INFORMANT Address <u>Mrs. Frozie Duvall; Miller, 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>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <u>Arteriosclerosis</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)							INTERVAL BETWEEN ONSET AND DEATH <u>3 hr</u> <u>years?</u>		
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 _____ a.m. _____ p.m.		Month, Day, Year _____							
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 <u>Aug 1, 1959</u> to <u>Aug 1, 1959</u> and last saw her <u>alive</u> on <u>Aug 1, 1959</u> Death occurred at <u>12:25</u> <u>p.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Emerw. Taylor M.D.</u>				22b. ADDRESS <u>Lockwood, Mo.</u>				22c. DATE SIGNED <u>8/3/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-3-1959</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>Round Grove</u>		23d. LOCATION (City, town, or county) (State) <u>N.W. of Miller, Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Morris-Leiman; Miller, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>8/4/1959</u>		26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 12 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *H. R. Leiman*

Licensed Embalmer No. 3297

P. O. Address Miller Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.