

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024944

FILED VS. JUL 27 1959

Primary Registration District No. 555 / Registrar's No. 81

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Novell</u>		2. USUAL RESIDENCE (Where deceased lived. At institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Novell</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) <u>West Plains</u>		Length of stay in 1b <u>16 yrs</u>	c. CITY OR TOWN <u>West Plains</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rural</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Gainsville Rd</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Cade</u> Middle <u>Eugene</u> Last <u>Scheeley</u>			4. DATE OF DEATH Month <u>7</u> Day <u>7</u> Year <u>1959</u>		
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-15-1884</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>22</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>Bedford, Va.</u>	11. BIRTHPLACE (city and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Daniel Scheeley</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Andrews</u>		13c. NAME OF HUSBAND OR WIFE <u>Abella Scheeley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Mrs C.E. Scheeley, West Plains</u> 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) <u>MYOCARDIAL INFARCTION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>
DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		<u>YEARS</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) <u>GIASTRO-ENTERITIS 24 hours</u> <u>ARTERIOSCLEROSIS</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 checked="" 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
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21. I attended the deceased from 1:00 p.m. 3-31-59 and last saw him alive on 7-15-59
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Jack N. Wiles, M.D.</u>	(Doctor or title)	22b. ADDRESS <u>West Plains, Mo.</u>	22c. DATE SIGNED <u>7-20-59</u>
23a. BURIAL, CREMATION, REINTERMENT (Specify)	23b. DATE <u>7-10-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fowler</u>	23d. LOCATION (city, town or county) (State) <u>Carroll, MO</u>
24. FUNERAL DIRECTOR <u>Charles M. West</u>	ADDRESS <u>West Plains, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>7-21-59</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed *A. L. Roberts*

Licensed Embalmer No. 34

P. O. Address *West*

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