

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028582

FILED VS SEP 8 1959

Registration District No. Primary Registration District No. 3018 Registrar's No. 63

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Dent</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Bollinger</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Salem</u>		Length of stay in 1b <u>15 months</u>		c. CITY OR TOWN <u>Rural Rte 1</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Knox Nursing Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rural Rte 1, Perryville, Mo.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>MUGGIE</u> Last <u>SHRUM</u>				4. DATE OF DEATH Month <u>August</u> Day <u>30</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>12/13/82</u>		9. AGE (last birthday) <u>76</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
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>At home</u>		11. BIRTHPLACE (City and state or country) <u>Lixville, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>William Wills</u>			13b. MOTHER'S MAIDEN NAME <u>Barbara Hilderbrand</u>			14. NAME OF HUSBAND OR WIFE <u>Jeff Shrum (Decd)</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 <u>Loy Shrum</u> Address <u>2622 Solway Jennings, Missouri</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>CARDIO-VASCULAR 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.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>INANITION.</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			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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>1957</u> to <u>1959</u> and last saw her/him alive on <u>Aug 30, 59</u> Death occurred at <u>7:30 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Joseph R. Bunce</u> (Degree or title)				22b. ADDRESS <u>445E High Potomac, Mo</u>				22c. DATE SIGNED <u>9-1-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem & Burial</u>		23b. DATE <u>9/2/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Crossroads Cemetery</u>		23d. LOCATION (City, town, or county) <u>Bollinger County Mo.</u>			
24. FUNERAL DIRECTOR <u>Max L. Warfel</u> ADDRESS <u>Salem, Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>9/1/59</u>		26. REGISTRAR'S SIGNATURE <u>M. M. Hart</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 Max L. Wenf

Licensed Embalmer No. 4170

P. O. Address Salem,

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.