

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-029314**

FILED VS SEP 4 1959 149

1002

3938

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Jackson</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b> Length of stay in 1b <b>1 wk.</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b> c. CITY OR TOWN <b>Sweet Springs</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>337 W. Main</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Etta</b> Middle <b>L.</b> Last <b>Shull</b>			<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>13</b> Year <b>1959</b>			
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>9-8-1886</b>	<b>9. AGE (last birthday)</b> <b>72</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Ozark, Mo.</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U. S.</b>	
<b>13a. FATHER'S NAME</b> <b>Robert Smith</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Martha Gonce</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Jacob F. Shull</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT</b> Address <b>Mrs. L. Lockney Sweet Springs, Mo.</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive heart failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerotic cardio vascular disease</b> DUE TO (c) <b>generalized atherosclerosis</b>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>gastroenterostomy for obstructing duodenal ulcer</b>					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	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____						
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE		
<b>21. I attended the deceased from</b> <b>August 1, 1959</b> to <b>death</b> and last saw her/him alive on <b>Aug. 12, 1959</b> Death occurred at <b>2:30 A. M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
<b>22a. SIGNATURE</b> (Degree or title) <b>X Kennard, M.D.</b>			<b>22b. ADDRESS</b> <b>4635 Wyandotte</b>		<b>22c. DATE SIGNED</b> <b>8-13-59</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>removal</b>		<b>23b. DATE</b> <b>8-15-59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Crown Hill Cem.</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Sedalia, Mo.</b>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>L. F. Parker Sweet Springs, Mo.</b>			<b>RECD. BY LOCAL REG.</b> <b>8-13-59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Neva Minshall</b>	

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 L. F. Parker

Licensed Embalmer No. 3840

P. O. Address Sweet Springs

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.