

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031487

FILED VS OCT 5 1959 37

Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 39

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Andrew</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Centralia</u>		Length of stay in 1b <u>5 Weeks</u>		c. CITY OR TOWN <u>Vandalia</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>Zulen Nursing Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>State Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Henry Shuck</u>				4. DATE OF DEATH Month Day Year <u>8 29 59</u>									
5. SEX <u>Male</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>1-17-1882</u>		9. AGE (last birthday) <u>77</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Janitor</u>		11. BIRTHPLACE (City and state or country) <u>Lincoln Co. Mo</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>William Shuck</u>			13b. MOTHER'S MAIDEN NAME <u>Malissa Blackeby</u>			14. NAME OF HUSBAND OR WIFE <u>Corra Shuck</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT Address <u>Zulen Nursing Home, Centralia, Mo</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u>										<u>4 days</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>multiple cerebral thrombosis</u>										<u>months</u>			
DUE TO (c) <u>cerebral arteriosclerosis</u>										<u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							PART III. If deceased was female was there a pregnancy in last 90 d-ys <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
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 1b.)									
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>1/31/59</u> to <u>8/28/59</u> and last saw her/him alive on <u>8/28/59</u> Death occurred at <u>approximately 4</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Robert L. Ward</u> (Degree or title) <u>MD</u>				22b. ADDRESS <u>Centralia - Mo.</u>				22c. DATE SIGNED <u>8/29-1959</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8/31/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Millwood Cemetery</u>			23d. LOCATION (City, town, or county) <u>Millwood, Mo.</u> (State)						
24. FUNERAL DIRECTOR <u>William Steves Vandalia, Mo</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>Oct 2-1959</u>				26. REGISTRAR'S SIGNATURE <u>Maud M<sup>rs</sup> Bride</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 William Alsters

Licensed Embalmer No. 4169

P. O. Address Vandusia

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