

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035650

FILED VS OCT 27 1959

Registration District No. 86 Primary Registration District No. 4189 Registrar's No. 28-1959 STATE FILE NUMBER

UNDECEASED

| | | | | | | |
|---|---|---|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Crawford</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cuba</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cuba Senior Citizens Home</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u> c. CITY OR TOWN <u>Cuba</u> d. STREET ADDRESS (If outside, give location) | | |
| Length of stay in 1b <u>4 Months</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>ASH</u> Middle Last <u>Shoults</u> | | | 4. DATE OF DEATH Month <u>October</u> Day <u>13</u> Year <u>1959</u> | | | |
| 5. SEX <u>Male</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>9/26/1885</u> | 9. AGE (last birthday) <u>74</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>17</u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>P.A. Financier</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or territory) <u>Cuba, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
| 13a. FATHER'S NAME <u>Henry Shoults</u> | | 13b. MOTHER'S MAIDEN NAME <u>Sarah Frances White</u> | | 14. NAME OF HUSBAND OR WIFE <u>Mable (Deceased)</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>480-26-9644</u> | 17. INFORMANT Address <u>Blanche Cook Cuba, 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 Ventricular Dilatation</u> DUE TO (b) <u>due to atherosclerotic heart disease</u> DUE TO (c) <u>disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>20 yrs</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 days. <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 18.) | | | | |
| 20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u> | 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 | |
| 21. I attended the deceased from <u>Sept 1958</u> to <u>Oct 13, 1959</u> and last saw ^{her} him alive on <u>Aug 28, 1959</u> Death occurred at <u> </u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Frank H. Elden, M.D.</u> | | | 22b. ADDRESS <u>Cuba, Mo.</u> | | 22c. DATE SIGNED <u>10/13/59</u> | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY <u>Kindred Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>Cuba, Mo.</u> | | |
| 24. FUNERAL DIRECTOR <u>Paul A. Franklin</u> | | ADDRESS <u>Cuba, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>10-13-1959</u> | 26. REGISTRAR'S SIGNATURE <u>Paul A. Franklin</u> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

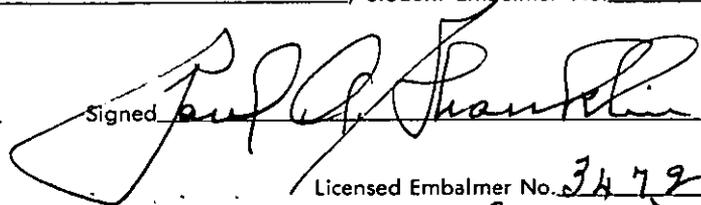
STATEMENT BY LICENSED EMBALMER

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

Student _____

Signature of Student Embalmer

Signed



Licensed Embalmer No. 3472

P. O. Address Cuba, Mo.

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.