

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036578

FILED VS NOV 2 1959

STATE FILE NUMBER

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 234

ENDED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Prarie</u>		Length of stay in 1b <u>2 mo.</u>	c. CITY OR TOWN <u>Indep. mo</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>Jackson County Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1011 S. Cottage</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Sheldon</u> Last <u>Sheldon</u>			4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>59</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>5-4-1871</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </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>Home Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>macon mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	

13a. FATHER'S NAME <u>Fredrick Polbey</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Thomas J Sheldon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records Dept. Hospital</u>	
				Address <u>Indep. 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>Arterio-sclerotic heart disease</u>	
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.	<u>Generalized Arterio sclerosis</u>	
DUE TO (b)		
DUE TO (c)		

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
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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 <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>	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 <u> </u> STATE <u> </u>

21. I attended the deceased from 8-18-59 to 10-18-59 and last saw her alive on 10-17-59
Death occurred at 19-18-59 7:25 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>July Paper M.D.</u>	(Degree of title)	22b. ADDRESS <u>Deer Summit Mo</u>	22c. DATE SIGNED <u>10/19/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Oct 21, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wood Grove</u>	23d. LOCATION (City, town, or county) <u>Indep Mo.</u>
24. FUNERAL DIRECTOR <u>Paul R Speaks</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>10-20-1959</u>	26. REGISTRAR'S SIGNATURE <u>W. B. Longford</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 14 1980

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 Dennis H. Miller

Licensed Embalmer No. 4783

P. O. Address Del Rio

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.