

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 22 1960

=60-000075

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 9

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Audrain</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Audrain</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico</u>		Length of stay in 1b	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>Audrain County Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Vandalia Hotel</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>Johnson</u> Last <u>Shuck</u>			4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1960</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>Oct 31 1881</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Ralls County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>
13a. FATHER'S NAME <u>Robert Lee Shuck</u>		13b. MOTHER'S MAIDEN NAME <u>Leona Belle Nutgrass</u>		14. NAME OF HUSBAND OR WIFE <u>Virgie Allison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>490 10 8456</u>		17. INFORMANT <u>Everett McGrew</u> Address <u>Ladonia, 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 <u>1-10-60</u> <u>6-11-60</u>
IMMEDIATE CAUSE (a) <u>cerebral Hemorrhage - with paralysis - last arm &amp; leg</u>					
DUE TO (b) <u>Hypertensive Cardiovascular Disease</u>					<u>5-24-58</u>
DUE TO (c) <u>Generalized Arteriosclerosis -</u>					<u>?</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 checked="" 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 checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>X</u>			
20c. TIME OF INJURY Hour <u>1</u> Month, Day, Year <u>1</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.) <u>X</u>	20f. CITY, TOWN, OR LOCATION <u>Vandalia</u>		COUNTY	STATE
21. I attended the deceased from <u>1-10-60</u> to <u>1-11-60</u> and last saw <u>her</u> him alive on <u>1-10-60</u> Death occurred at <u>1-11-60</u> <u>4:30</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>K. Amy F. O'Brien M.D.</u> (Degree or title)			22b. ADDRESS <u>Mexico Missouri</u>		22c. DATE SIGNED <u>1/21/60</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan. 13 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Vandalia Cemetery</u>		23d. LOCATION (City, town, or county) <u>Vandalia, Mo.</u>	
24. FUNERAL DIRECTOR <u>W. B. Waters</u> ADDRESS <u>Vandalia, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Jan 11-19-60</u>	26. REGISTRAR'S SIGNATURE <u>Blanche Neely</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

FEB 8

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 B. Wat

Licensed Embalmer No. 4169  
P. O. Address Vandalia, Vt

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.