

DI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000397  
STATE FILE NUMBER

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STATE FILE NUMBER

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1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b Life		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2805 Angeliue St.,			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 802 North 9th St.,		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Marie Middle M. Last Shady				4. DATE OF DEATH January 10, 1960									
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH June 13, 1881		9. AGE (last birthday) 78		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) Lincoln, Nebraska		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME Unknown				13b. MOTHER'S MAIDEN NAME Unknown				14. NAME OF HUSBAND OR WIFE L. A. Shady					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Lewis C. Shady, St. Joseph, Missouri							
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>Ventricular fibrillation</u>										INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary insufficiency</u>										?			
DUE TO (c) <u>Atherosclerotic heart disease</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 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>11-17-59</u> to <u>1-10-60</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>12-25-59</u> Death occurred at <u>10:30</u> P. m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Lucien H. Ide M.D.</u>						22b. ADDRESS <u>902 Edmund St. Joseph, Mo</u>			22c. DATE SIGNED <u>1-14-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Jan. 13, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>			23d. LOCATION (City, town, or county) <u>St. Joseph, Missouri</u>			(State)			
24. FUNERAL DIRECTOR <u>Mrs. Schaffer - Hegeman Inc.</u> ADDRESS <u>St. Joseph, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Jan. 20, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>							

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION  
L. W. Ide, M.D.

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 Albert R. Harrington

Licensed Embalmer No. 3250

P. O. Address H. Pa.

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.