

# IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005938

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Registration District No. 28 Primary Registration District No. 2000 Registrar's No. 279

STATE FILE NUMBER

|   |   |  |  |   |   |  |  |
|---|---|--|--|---|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>GREENE</u><br>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u> Length of stay in lb <u>38 YRS.</u><br>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DAVIS REST HOME</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u><br>c. CITY OR TOWN <u>SPRINGFIELD</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br>d. STREET ADDRESS (If outside, give location) <u>1610 E. CATALPA</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) First <u>IDA</u> Middle <u>GRAY</u> Last <u>SHOCKLEY</u>   |   |  | <b>4. DATE OF DEATH</b> Month <u>MARCH</u> Day <u>3</u> Year <u>1960</u> |   |   |  |  |
| <b>5. SEX</b><br><u>FEMALE</u>  | <b>6. COLOR OR RACE</b><br><u>WHITE</u> | <b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>12/6/75</u>                                | <b>9. AGE (last birthday)</b><br><u>84</u>  | <b>IF UNDER 1 YEAR</b><br>Months _____ Days _____                               | <b>IF UNDER 24 HR</b><br>Hours _____ Min. _____  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during part of working life, even if retired)<br><u>HOME</u>   |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>   |  | <b>11. BIRTHPLACE</b> (City and state or country)<br><u>RICHLAND, MO.</u>   |   | <b>12. CITIZEN OF WHAT COUNTRY</b><br><u>USA</u> |  |
| <b>13a. FATHER'S NAME</b><br><u>WARREN BARR</u>   |   |  | <b>13b. MOTHER'S MAIDEN NAME</b><br><u>MARY FRANCES BATCHLER</u>         |   | <b>14. NAME OF HUSBAND OR WIFE</b><br><u>WILLIAM M. SHOCKLEY (DEC)</u>          |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |   | <b>16. SOCIAL SECURITY NO.</b><br><u>NO</u>  |  | <b>17. INFORMANT</b> Address <u>LEONARD M. SHOCKLEY, SPRINGFIELD, MO</u>  |   |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | <b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>                                     |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)<br><u>None</u>  |   |  |  |
| <b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ Month, Day, Year <u>None</u>   |   | <b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____   |   | <b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE |  |
| <b>21. I attended the deceased from</b> <u>11-21-56</u> to <u>3-3-60</u> and last saw her <sup>him</sup> alive on <u>3-3-60</u><br>Death occurred at <u>7 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.   |   |  |  |   |   |  |  |
| <b>22a. SIGNATURE</b> (Degree or title)<br><u>W. Paul, M.D.</u>   |   |  |  | <b>22b. ADDRESS</b><br><u>609 Cherry Springfield, Mo</u>  |   | <b>22c. DATE SIGNED</b><br><u>3/4/60</u>         |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>BURIAL</u>   |   | <b>23b. DATE</b><br><u>3/5/60</u>  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>GREENLAWN</u>            |   | <b>23d. LOCATION</b> (City, town, or county) (State)<br><u>SPRINGFIELD, MO.</u> |  |  |
| <b>24. FUNERAL DIRECTOR</b> ADDRESS<br><u>H. H. LOHMEYER, SPRINGFIELD, MO.</u>  |   |  | <b>25. DATE RECD. BY LOCAL REG.</b><br><u>3-7-60</u>                     |   | <b>26. REGISTRAR'S SIGNATURE</b><br><u>Effie S. Melton</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 AK MC Carr

Licensed Embalmer No. 2727

P. O. Address Appl mo

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.