

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014121

FILED VS APR 29 1960 13

5062

57

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Barry</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Barry</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Purdy Twp.</b>		Length of stay in 1b <b>18 mo.</b>		c. CITY OR TOWN <b>Purdy</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>WESLEY</b> Last <b>SHULTZ</b>				4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1960</b>									
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9-1-1878</b>		9. AGE (last birthday) <b>81</b>		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) <b>owner-operator</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>cafe</b>			11. BIRTHPLACE (City and state or country) <b>Illinois</b>			12. CITIZEN OF WHAT COUNTRY <b>UNKnown</b>				
13a. FATHER'S NAME <b>unknown</b>				13b. MOTHER'S MAIDEN NAME <b>unknown</b>				14. NAME OF HUSBAND OR WIFE <b>Lottie Shultz</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Edward Shultz-Los Angeles Calif.</b> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO (b) <b>arteriosclerotic heart disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH			
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 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 <b>12-4-1958</b> to <b>1-7-1960</b> and last saw <sup>her</sup> him alive on <b>1-7-60</b> Death occurred at <b>9 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>Charles H. Rice M.D.</b>						22b. ADDRESS <b>Cassville Missouri</b>			22c. DATE SIGNED <b>4-18-60</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-19-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Cassville Missouri</b>						
24. FUNERAL DIRECTOR <b>Culver's</b>				ADDRESS <b>Cassville, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>4-19-60</b>		26. REGISTRAR'S SIGNATURE <b>Ms. P. N. Cook</b>					

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 Margaret C. Henbest

Licensed Embalmer No. 4389

P. O. Address Crossville,

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.