

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## =60-014558

FILED VS APR 20 1960 7/

Registration District No. 7/ Primary Registration District No. 3012 Registrar's No. 32

STATE FILE NUMBER

|   |   |   |  |   |   |  |   |
|---|---|---|--|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Clay</u>  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u> |   |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Excelsior Springs</u>   |   | Length of stay in 1b<br><u>17 yrs.</u>  |  | c. CITY OR TOWN <u>Excelsior Springs</u>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>618 Old Orchard</u>   |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>         | d. STREET ADDRESS (If outside, give location)<br><u>618 Old Orchard</u>   |   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>STANLEY</u> Middle <u>ROY</u> Last <u>SHARA</u>   |   |   |  | 4. DATE OF DEATH<br>Month <u>March</u> Day <u>18</u> Year <u>1960</u>   |   |  |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>5-8-1891</u>   | 9. AGE (last birthday)<br><u>68</u>   | IF UNDER 1 YEAR<br>Months <u>        </u> Days <u>        </u>   | IF UNDER 24 HR<br>Hours <u>        </u> Min. <u>        </u>                          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Doctor</u>  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Chiropractic</u>                                     |   | 11. BIRTHPLACE (City and state or country)<br><u>Narka, Kansas</u>                            |  | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>   |
| 13a. FATHER'S NAME<br><u>John Shara</u>   |   |   | 13b. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |   |   | 14. NAME OF HUSBAND OR WIFE<br><u>Olive H. Shara</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |   |   | 16. SOCIAL SECURITY NO.<br><u>515-18-7194</u>  |   | 17. INFORMANT<br><u>Olive Shara, Excelsior Springs, Mo.</u><br>Address <u>618 Old Orchard</u> |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>DUE TO (b) <u>Hypertension</u><br>DUE TO (c) <u>Arteriosclerosis</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |   |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>45'</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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour <u>        </u> a.m. <u>        </u> p.m. <u>        </u><br>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   | STATE   |
| 21. I attended the deceased from <u>Feb '53</u> to <u>18 Mar '60</u> and last saw him alive on <u>3-10-60</u><br>Death occurred at <u>2:36 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.  |   |   |  |   |   |  |   |
| 22a. SIGNATURE (Degree or title)<br><u>George E Sanders M.D.</u>  |   |   |  | 22b. ADDRESS<br><u>Excelsior Springs, Mo.</u>   |   | 22c. DATE SIGNED<br><u>3-18-60</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |   | 23b. DATE<br><u>3-21-60</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Masonic Cemetery</u>                                |   | 23d. LOCATION (City, town, or county) (State)<br><u>Excelsior Springs, Mo.</u>                |  |   |
| 24. FUNERAL DIRECTOR<br><u>Richard Funeral Home, Inc.</u><br><u>Excelsior Springs, Missouri</u>   |   |   |  | 25. DATE RECD. BY LOCAL REG.<br><u>4-6-60</u>   |   | 26. REGISTRAR'S SIGNATURE<br><u>Caroline Hutchings</u>   |   |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 15 1961

**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 Lindsey Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.