

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014976

FILED VS MAY 2 1960

Registration District No. 128 Primary Registration District No. _____ Registrar's No. 409B

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Greene</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Walnut Grove, Mo, Rt #2</u>		Length of stay in 1b <u>15 yrs</u>		c. CITY OR TOWN <u>Walnut Grove, Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Walnut Grove Mo, Rt # 2</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Shubbach</u>				4. DATE OF DEATH Month Day Year <u>April 9 1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5/10/1893</u>	9. AGE (last birthday) <u>66</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Christian Co, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		
13a. FATHER'S NAME <u>G.F. Shubbach</u>			13b. MOTHER'S MAIDEN NAME <u>Bertha Glouser</u>		14. NAME OF HUSBAND OR WIFE <u>Marie Shubbach</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 1st W. War</u>		16. SOCIAL SECURITY NO. <u>495-40-5172</u>		17. INFORMANT Address # <u>2</u> MO <u>Mrs Marie Shubbach, Walnut Grove,</u>				
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>Likely Coronary Occlusion</u> DUE TO (b) <u>Likely Coronary Sclerosis</u> DUE TO (c) <u>UNATTENDED BY A PHYSICIAN</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>It was stated that he was a diabetic</u>						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 _____ to _____ and last saw her/him alive on _____ Death occurred at <u>4/9/60 - 11 P M</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>James R. Amos M.D. Greene</u>				22b. ADDRESS <u>County Health Officer, Spfld Mo</u>		22c. DATE SIGNED <u>4-25-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/12/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shubbach</u>		23d. LOCATION (City, town, or county) (State) <u>Christian Co Mo</u>			
24. FUNERAL DIRECTOR <u>T. B. Chaffin Ozark Mo.</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>4-25-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

