

VITAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-023835

STATE FILE NUMBER

FILED VS JUL 8 1960

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 261

1. PLACE OF DEATH a. COUNTY <u>Marion</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u> Length of stay in lb <u>10 yrs</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>421 Fulton Ave</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Marion</u> c. CITY OR TOWN <u>Hannibal</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>421 Fulton Ave</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>James</u> Last <u>Shawly</u>				4. DATE OF DEATH Month <u>7</u> - Day <u>2</u> - Year <u>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>11-6-86</u>	9. AGE (last birthday) <u>73</u>	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) <u>Farmer (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Scotland Co., Mo.</u>		11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Emmett Shawly</u>		13b. MOTHER'S MAIDEN NAME <u>Sylpha Roseberry</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Shawly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mary Shawly - Hannibal, Mo.</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>Coronary thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>60 seconds</u> DUE TO (b) <u>Generalized arteriosclerosis</u> <u>15 yrs</u> DUE TO (c) <u>Diabetes Mellitus</u> <u>10 yrs</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>Dec. 31-1954</u> to <u>July 2-1960</u> and last saw him <u>alive on June 10-1960</u> Death occurred at <u>11:35 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Of doctor or title) <u>E. M. Lucke D.O.</u>				22b. ADDRESS <u>412 Center St. Hannibal, Mo.</u>		22c. DATE SIGNED <u>7/4/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-5-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hannibal, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Clark Funeral Home - Hannibal, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>7/5/60</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke by William M. Gorman</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  _____

Licensed Embalmer No. 4217

P. O. Address Hannibal, 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.