

Dept. Health,  
S. Public  
Health Service

FILED VS AUG 15 1960

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-60-027664

Registration District No. 212 Primary Registration District No. 3044 Registrar's No. 24

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>MILLER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MILLER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ELDON</u>		c. CITY OR TOWN <u>ELDON 06612</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>638-E-NORTH ST</u>		d. STREET ADDRESS (If outside, give location) <u>638-E-NORTH</u>	
Length of stay in 1b <u>29 yrs 90</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>John F.C. PAULSON</u>			4. DATE OF DEATH Month Day Year <u>July 23 1960</u>		
5. SEX <u>Female</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>13 MAY-1887</u>		9. AGE (In years <sup>11</sup> UNDER 1 YEAR <sup>11</sup> IF UNDER 24 HRS Last birthday) Months Days Hours Min. <u>73</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES-CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INTER-HARVESTING</u>		11. BIRTHPLACE (City and state or country) <u>LeMARS - IOWA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>HANS-PAULSON</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZA-CHRISTENSON</u>	
14. NAME OF HUSBAND OR WIFE <u>Louise-PAULSON</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. <u>None</u>	
17. INFORMANT <u>Louise-PAULSON</u>		Address <u>ELDON-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>Cerebral Hemorrhage.</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to the cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio-sclerosis &amp; hypertension</u>			
DUE TO (c) <u>331 X H</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Prostatic Carcinoma</u>			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.) <u>NONE</u>		
20c. TIME OF INJURY Hour Month, Day, Year o.m. p.m. <u>NONE</u>			

20d. INJURY OCCURRED WHILE AT <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.) <u>NONE</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>NONE</u>	
21. I attended the deceased from <u>1958</u> to <u>July 23 1960</u> and how long he was alive on <u>July 22 1960</u> Death occurred at <u>5:20 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>E. O. Shelton M.D.</u>		22b. ADDRESS <u>ELDON Mo</u>	22c. DATE SIGNED (Date) <u>25 July 1960</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>25 July-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ELDON</u>	23d. LOCATION (City, town, or county) <u>ELDON Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Keith M. Kays ELDON-MO</u>		25. DATE RECD. BY LOCAL REG. <u>July 25, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Alverta W. Dalt</u>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

2-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Keith M. Fays* .....

Licensed Embalmer No. *399* .....

P. O. Address *Eldon, Mo.* .....

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