

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-029604

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

|  |  |  |  |  |  |  |   |  |                                   |   |  |  |  |
|--|--|--|--|--|--|--|---|--|-----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Bollinger</u>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Bollinger</u>                                |  |  |   |  |                                   |   |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>near Dongola, Rural</u>  |  | Length of stay in 1b   |  | c. CITY OR TOWN <u>Sturdivant</u>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |  |                                   |   |  |  |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Hy. 51</u>   |  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location)<br><u>Wayne Twp.</u> |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |                                   |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Leeman</u> Middle <u>E.</u> Last <u>Shell</u>  |  |  |  | 4. DATE OF DEATH<br>Month <u>Aug.</u> Day <u>30,</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>7/9/1915</u>  |   | 9. AGE (last birthday)<br><u>45</u>  |                                   | IF UNDER 1 YEAR<br>Months <u>1</u> Days _____ |  | IF UNDER 24 HR<br>Hours <u>21</u> Min. _____ |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farming</u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Farm</u>   |  | 11. BIRTHPLACE (City and state or country)<br><u>Bollinger County, Mo.</u>           |   | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>   |                                   |   |  |  |  |
| 13a. FATHER'S NAME<br><u>William A. Shell</u>  |  |  |  | 13b. MOTHER'S MAIDEN NAME<br><u>Bertha Shell</u>   |  |  |   | 14. NAME OF HUSBAND OR WIFE<br><u>Lyla Baker Shell</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>486-46-7121</u>  |  | 17. INFORMANT Address<br><u>Lyla Shell, Sturdivant, Mo.</u>                          |   |  |                                   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |   |  |                                   | INTERVAL BETWEEN ONSET AND DEATH              |  |  |  |
| IMMEDIATE CAUSE (a) <u>Broken neck</u>   |  |  |  |  |  |  |   |  |                                   |   |  |  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Auto Accident</u><br>DUE TO (c) <u>Rear truck wheel ran over head</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 checked="" type="checkbox"/>  |  | 20a. ACCIDENT <input checked="" 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.)<br><u>Thrown out of truck when it left road no witnesses to accident.</u> |  |  |   |  |                                   |   |  |  |  |
| 20c. TIME OF INJURY<br>Hour <u>11:00</u> p.m. Month, Day, Year <u>8/30/60</u>  |  | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>    |  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><u>road</u>  |  | 20f. CITY, TOWN, OR LOCATION<br><u>near Dongola, Bollinger, Mo.</u>                  |   | COUNTY   |                                   | STATE   |  |  |  |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on <u>8/30/60</u> at _____ on the date stated above, and to the best of my knowledge, from the causes stated.<br>Death occurred at <u>8/30/60</u> |  |  |  |  |  |  |   |  |                                   |   |  |  |  |
| 22a. SIGNATURE (Degree or title)<br><u>John J. Myers D. O.</u>   |  |  |  |  |  | 22b. ADDRESS<br><u>Lutesville, Mo.</u>   |   |  | 22c. DATE SIGNED<br><u>9/7/60</u> |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE<br><u>9/2/60</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Morgan Memorial Park</u>  |  |  |   | 23d. LOCATION (City, town, or county) (State)<br><u>Advance, Mo.</u>   |                                   |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Morgan Funeral Home, Lutesville, Mo.</u>  |  |  |  | 25. DATE RECD. BY LOCAL REG.<br><u>9-8-60</u>  |  | 26. REGISTRAR'S SIGNATURE<br><u>Mr. Buford Crader.</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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W<sup>m</sup> H. Morgan

Licensed Embalmer No. 464

P. O. Address Advance

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