

# IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-030787

FILED VS. SEP 12 1960 *149*

Registration District No. \_\_\_\_\_

Primary Registration District No. *1002*

Registrar's No. *4357*

STATE FILE NUMBER \_\_\_\_\_

VOIDED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>JACKSON</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <i>Pettis</i>							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in lb <b>15 days</b>		c. CITY OR TOWN <b>SEDALIA</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V A HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>700 WEST THIRD</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <b>EVERETT</b> Middle _____ Last <b>SHAW</b>				<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>23</b> Year <b>1960</b>							
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>1-10-95</b>		<b>9. AGE (last birthday)</b> <b>65</b>		IF UNDER 1 YEAR IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Osteopathic physician</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Retired</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Mt. Sterling, Iowa</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>				
<b>13a. FATHER'S NAME</b> <b>Fred Shaw</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Emma Kerr</b>			<b>14. NAME OF HUSBAND OR WIFE</b> <b>Ruth Shaw</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WWI</b>				<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> <b>VA Hospital Official Rcds, K.C. Mo.</b> <b>Ruth Shaw, 700 West 3rd, Sedalia, Mo.</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								INTERVAL BETWEEN ONSET AND DEATH _____			
IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>								_____			
DUE TO (b) <b>Old and probable recent infarctions of left ventricle</b>								_____			
DUE TO (c) <b>Atherosclerosis and focal occlusions of coronary arteries</b>								_____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes mellitus</b>						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					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____							
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____ <b>STATE</b> _____			
<b>21. I attended the deceased from</b> <b>August 8, 1960</b> <b>August 23, 1960</b> and <b>last seen</b> <b>conscious</b> Death occurred at <b>4:25 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.											
<b>22a. SIGNATURE</b> (Degree or title) <b>T. J. FRITZLEN, M.D.</b> <i>T. J. Fritzlen</i>				<b>22b. ADDRESS</b> <b>VA Hospital, Kansas City, Mo.</b>		<b>22c. DATE SIGNED</b> <b>8-24-60</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>		<b>23b. DATE</b> <b>8-26-60</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Memorial Park</b>		<b>23d. LOCATION (City, town, or county)</b> <b>Sedalia, Missouri</b>					
<b>24. FUNERAL DIRECTOR</b> <b>Gillespie Funeral Home, Sedalia, Mo.</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>8-24-60</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>H. L. Dwyer</i>					

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 D. W. Zuckert

Licensed Embalmer No. 3704

P. O. Address Sedalia, Mo

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.