

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031350

FILED VS. AUG 25 1960

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 333

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY MARION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE OKLAHOMA b. COUNTY MAJOR								
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN HANNIBAL		Length of stay in 1b		c. CITY OR TOWN RINGWOOD		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St ELIZABETH HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) ROUTE 1		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First CLARENCE Middle BOYD Last SHAFFER JR				4. DATE OF DEATH Month AUGUST Day 20 Year 1960								
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8-6-1935	9. AGE (last birthday) 25	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONCRETE FINISHER			10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (City and state or country) RING WOOD, OKLAHOMA		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME CLARENCE SHAFFER			13b. MOTHER'S MAIDEN NAME ELIZABETH LEE			14. NAME OF HUSBAND OR WIFE RUBY SHAFFER						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 440-38-9741		17. INFORMANT Mrs. Clarence Shaffer Ringwood Address Okla							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basilar skull fracture & severe cerebral contusion								INTERVAL BETWEEN ONSET AND DEATH 4 hrs				
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)				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 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.) Fell 18 ft. from head house of elevator to 1st. level								
20c. TIME OF INJURY 5:50 p.m.		Month, Day, Year 8-20-1960			20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) Grain Elevator		20f. CITY, TOWN, OR LOCATION Monroe City		COUNTY Monroe	STATE Mo.
21. I attended the deceased from Aug. 20 to Aug. 20 and last saw him alive on Aug 20 Death occurred at 10 P. m on the date stated above, and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE (Degree or title) R. M. Strong M.D.						22b. ADDRESS Hannibal, Missouri			22c. DATE SIGNED 8/20/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 8-21-60	23c. NAME OF CEMETERY Pleasant Hill			23d. LOCATION (City, town, or county) Meno, Oklahoma			(State)			
24. FUNERAL DIRECTOR Wilson & Son Monroe City Mo				ADDRESS Monroe City Mo		25. DATE RECD. BY LOCAL REG. 8/22/60		26. REGISTRAR'S SIGNATURE Dr. E. M. Ruske by William M. Therman				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 7 1960

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 Me _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Leslie L. Nelson _____

Licensed Embalmer No. 3014
P. O. Address Monroe City

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