

FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE
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JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

ED VS OCT 24 1960

-60-038081
 STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1029A

1. PLACE OF DEATH a. COUNTY <u>Greene</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield, Mo</u>		Length of stay in lb <u>10 days</u>	c. CITY OR TOWN <u>Springfield Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Handley Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Mercy Hospital, Springfield</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Williel</u> Middle <u>Shurte</u> Last <u>Shurte</u>			4. DATE OF DEATH <u>October 9, 1960</u> Month <u>October</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/60</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Christian Co, Mo</u>		
12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		13a. FATHER'S NAME <u>Not Known</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ann Smith</u>		
14. NAME OF HUSBAND OR WIFE		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>723-05-0395</u>		
17. INFORMANT <u>Albert Smith, Ozark, 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>Bronchopneumonia</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>ASHD = Cong. Heart Fail</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>	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	
20f. STATE	21. I attended the deceased from <u>9/27/60</u> to <u>10/9/60</u> and last saw her alive on <u>10/9/60</u> Death occurred at <u>10/9/60 - 8:20 A M</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Don E. Mencheth, M.D.</u>			22b. ADDRESS <u>1630 N. Jefferson</u>		22c. DATE SIGNED <u>10/17/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/11/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shipman Cemetry</u>		23d. LOCATION (City, town, or county) (State) <u>Christian Co, Mo</u>		
24. FUNERAL DIRECTOR <u>D. B. Chaffin, Ozark, Mo</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>10-19-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 8 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 A. B. Chaffin, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed A. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address _____

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.