

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041746

FILED VS DEC 6 1960 133

Registration District No. _____ Primary Registration District No. 3022 Registrar's No. 134

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY <u>Harrison</u> <u>Mo</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Harrison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bethany</u>		Length of stay in 1b <u>2 wks.</u>	c. CITY OR TOWN <u>Ridgeway Mo</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Holl Memorial Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>[check]</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Augusta</u> Last <u>Shain</u>	4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>1960</u>
---	--

5. SEX <u>Male</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>9-3-1876</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
--------------------	-------------------------------	--	----------------------------------	----------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state of country) <u>Harrison Co Mo U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	--	---	---

13a. FATHER'S NAME <u>John T. Shain</u>	13b. MOTHER'S MAIDEN NAME <u>Julia W. [unclear]</u>	14. NAME OF HUSBAND OR WIFE <u>Bessie Shain Deceased</u>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, posthumous) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT <u>Lula Shain, Ridgeway Mo</u>	Address _____
---	-----------------------------------	--	---------------

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>Carcinoma of Prostate with metastasis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>
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) <u>Heart block.</u>	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 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 _____ a.m. _____ p.m. Month, Day, Year _____

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 _____ STATE _____
--	--	---

21. I attended the deceased from 8/30/60 to 11-21-60 and last saw ^{her}him alive on 11-19-60
Death occurred at 9:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) <u>Marian Gearhart MD</u>	22b. ADDRESS <u>Bethany Mo</u>	22c. DATE/SIGNED <u>11/21/60</u>
--	--------------------------------	----------------------------------

23a. JOURNAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-25-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hobbs Chapel Cemetery</u>	23d. LOCATION (City, town, or county) <u>Capleville Mo</u>
--	---------------------------	---	--

24. FUNERAL DIRECTOR <u>Robbers Funeral Home, RR Boggs</u>	ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>11-26-1960</u>	26. REGISTRAR'S SIGNATURE <u>Gella Maxey</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 Robert R. Bossers

Licensed Embalmer No. 33-76

P. O. Address Ridgewood

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.