

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-60-048440**

ED VS JAN 9 1961 033

Registration District No. 3074 Registrar's No. 307

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Scott</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Scott</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Sikeston</b>			Length of stay in 1b		c. CITY OR TOWN <b>Sikeston</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MO DELTA COMM. HOSP.</b>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>217 N. Prairie Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Cristine</b> Middle <b>Maire</b> Last <b>Shanks</b>				4. DATE OF DEATH Month <b>12</b> Day <b>24</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1/22/32</b>	
9. AGE (last birthday) <b>28</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Manila, Ark.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Scott Montgomery</b>			13b. MOTHER'S MAIDEN NAME <b>Lucinda Hickam</b>			14. NAME OF HUSBAND OR WIFE <b>Charles F. Shanks</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <b>Mrs. E.C. Brasher, Keiser, Ark.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEAD INJURIES - BROKEN LEFT ARM - BOTH BGS BROKEN + INTERNAL INJURIES</b>							INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN.</b>
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.) <b>TWO CAR COLLISION</b>			
20c. TIME OF INJURY Hour <b>6:45 p.m.</b> Month, Day, Year <b>12-24-60</b>							
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.) <b>MALONE PRAIRIE ST.</b>		20f. CITY, TOWN, OR LOCATION <b>SIKESTON</b>		COUNTY STATE <b>SCOTT MO</b>	
21. I attended the deceased from _____ Death occurred at <b>7:15 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Clude Poe Coroner</b>				22b. ADDRESS <b>Sikeston Mo.</b>		22c. DATE SIGNED <b>12/29/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/28/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ermen</b>		23d. LOCATION (City, town, or county) (State) <b>Osceola, Arkansas</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Swift Funeral Home Osceola, Ark.</b>				25. DATE RECD. BY LOCAL REG. <b>12-29-60</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. E.C. Brasher</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 4 1961

NOV 13 1960

JUL 8 1961

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

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

Signed

*Raymond Lewis*

Licensed Embalmer No. 3467

P. O. Address Sekeston

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.