

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 146

Primary Registration District No. 5-568

Registrar's No. 99

STATE FILE NUMBER

61-005635

FILED VS FEB 28 1961

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Blue</b>		Length of stay in 1b <b>Life</b>	c. CITY OR TOWN <b>Rural</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>24 Highway, E. of Indep</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>R.R.#2, Indep., Mo.</b>
3. NAME OF DECEASED (Type or print) First <b>MR. LOUIE</b> Middle <b>N.M.I.</b> Last <b>SHRANK</b>			4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>1961</b>
5. SEX <b>Male</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>Fe. 14, 1878</b>
9. AGE (last birthday) <b>83</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>Retired-Mo. State Highway Department</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Jackson Co., Mo.</b>	11. BIRTHPLACE (City and state or country) <b>USA</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Jacob Shrank</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth</b>
14. NAME OF HUSBAND OR WIFE <b>Mollie Shrank</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. INFORMANT <b>Mrs. Mollie Shrank</b>		Address <b>R.R.#2, Indep., Mo.</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>Coronary Thrombosis - Acute</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>General Atherosclerosis - E</b> DUE TO (c) <b>Chronic Coronary Insufficiency 5 yrs.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Not known</b> <b>5 yrs.</b>
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 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 <b>3-4-60</b> to <b>2-20-61</b> and last saw <sup>him</sup> alive on <b>2-9-61</b> Death occurred at <b>PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Charles M. ...</b>		(Degree or title)	22b. ADDRESS <b>Independence, Mo</b>
22c. DATE SIGNED <b>2-21-61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb. 22, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Salem Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>5 miles E. of Indep. on 24 Hwy.</b>
24. FUNERAL DIRECTOR <b>OTT &amp; MITCHELL, Indep., Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>2-22-61</b>	26. REGISTRAR'S SIGNATURE <b>James ...</b>

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 2 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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed *[Handwritten Signature]*

Licensed Embalmer No. 3156

P. O. Address *[Handwritten 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.