

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-008435

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DR. ELLIS
AMENDED

Registration District No. 128 Primary Registration District No. 7002 Registrar's No. 310

STATE FILE NUMBER

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH 3 APR 3 1967

a. COUNTY GREENE

b. CITY (if outside corporate limits, give TOWNSHIP only) SPRINGFIELD Length of stay in lb LIFE

c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION BURGE HOSP. Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE MISSOURI b. COUNTY GREENE

c. CITY OR TOWN SPRINGFIELD Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) 2226 N. MAIN Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last

JUDITH ANN SHADWELL

4. DATE OF DEATH Month Day Year MARCH 25 1961

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. Married Never Married Widowed Divorced

8. DATE OF BIRTH 3/25/61 9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR

Months Days Hours Min. 1 23

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT 10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) SPRINGFIELD, MO. 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME CLYDE SHADWELL 13b. MOTHER'S MAIDEN NAME ROSA CAIN 14. NAME OF HUSBAND OR WIFE X

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. NO 17. INFORMANT Address CLYDE SHADWELL, SPRINGFIELD, MO.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congenital Atelectasis INTERVAL BETWEEN ONSET AND DEATH

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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour / Minute Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 Birth to _____ and last saw her/him alive on _____

Death occurred at 5:10 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. J. Ellis (Degree or title) MD 22b. ADDRESS Springfield Mo 22c. DATE SIGNED 3/27/61

23a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL 23b. DATE 3/27/61 23c. NAME OF CEMETERY OR CREMATORY GREENLAWN 23d. LOCATION (City, town, or county) SPRINGFIELD, MO.

24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER FUNERAL HOME 25. DATE RECD. BY LOCAL REG. 3-28-61 26. REGISTRAR'S SIGNATURE Effie J. Mellon

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 W L McC _____

Licensed Embalmer No. 2787

P. O. Address W L McC

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.