

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-023705

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 337 Primary Registration District No. 4496 Registrar's No. 36

FILED JUL 5 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>SHELBY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SHELBY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SHELBYVILLE</u> Length of stay in 1b <u>12 MONTHS</u>		c. CITY OR TOWN <u>SHELBYNA</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>PLEASANT HILL REST HOME</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>SHELBYNA MO</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY JOSEPHINE CLARSON</u>			4. DATE OF DEATH Month Day Year <u>JUNE 1 1961</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>5-19-1918</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR <u>83</u> Months Days Hours Min.
11a. FATHER'S NAME <u>JIM BOWNING</u>		11b. MOTHER'S MAIDEN NAME <u>MARY JANE ALBIN</u>	12. CITIZEN OF WHAT COUNTRY <u>US</u>
13a. FATHER'S NAME <u>JIM BOWNING</u>		14. NAME OF HUSBAND OR WIFE <u>J.W. CLARSON</u>	
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>---</u>	
17. INFORMANT <u>HOMER CLARSON</u>		Address <u>CLARENCE 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>Cerebral arterial insufficiency</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 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)			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 <u>Jan 1956</u> to <u>present</u> and last saw her <u>alive</u> on <u>May 23, 1961</u> . Death occurred at <u>11 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>Chas A. Riehl, MD</u>		22b. ADDRESS <u>Shelbyna Mo.</u>	22c. DATE SIGNED <u>6-3-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6-3-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SHELBYNA CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>SHELBYNA MO</u>
24. FUNERAL DIRECTOR <u>GREENING CLARENCE MO</u>		25. DATE RECD. BY LOCAL REG. <u>July 1-1961</u>	26. REGISTRAR'S SIGNATURE <u>Ada Garrison</u>

1961 9 7 00

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 Charles V. Heering

Licensed Embalmer No. 4625

P. O. Address Clarence

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.