

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-025870

STATE FILE NUMBER

Registration District No. 178 Primary Registration District No. _____ Registrar's No. 57

FILED AUG 1 1961

1. PLACE OF DEATH a. COUNTY LEWIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY LEWIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN LA BELLE TWSP.		c. CITY OR TOWN LEWISTOWN	
Length of stay in 1b XXXXX		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1 mi. No. Lewistown		d. STREET ADDRESS (If outside, give location) 1 mi. No. Lewistown	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) CYRUS ^{First} ROBB ^{Middle} SHANKS ^{Last}			4. DATE OF DEATH JULY 21, 1961		
--	--	--	--	--	--

5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/24/83	9. AGE (last birthday) 77	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) Farmer	10b. KIND OF BUSINESS OR INDUSTRY GENERAL	11. BIRTHPLACE (City and state or country) WILLIAMSTOWN, MO.	12. CITIZEN OF WHAT COUNTRY USA
--	---	--	---

13a. FATHER'S NAME JOHN SHANKS	13b. MOTHER'S MAIDEN NAME SUE BAYNE	14. NAME OF HUSBAND OR WIFE ELSIE TOMPKINS SHANKS
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO XXXXXXXX	17. INFORMANT Address ELSIE SHANKS LEWISTOWN, MISSOURI
---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH MINUTES
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 **(Never Attended Deceased Before)** and last saw **him** alive on **5:50 AM** on the date stated above, and to the best of my knowledge, from the causes stated.
Death occurred at _____

22a. SIGNATURE (Degree or title) Ralph V. Henry DO	22b. ADDRESS La Belle, Mo.	22c. DATE SIGNED 7-24-61
--	--------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 7/24/61	23c. NAME OF CEMETERY OR CREMATORY BENJAMIN	23d. LOCATION (City, town, or county) (State) BENJAMIN, MISSOURI
--	-----------------------------	---	--

24. GENERAL DIRECTOR ADDRESS Charles L. Arnold, Jr. LEWISTOWN, MO.	25. DATE RECD. BY LOCAL REG. 7-25-61	26. REGISTRAR'S SIGNATURE Mrs. Henry Lloyd
--	--	--

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF-

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

1967
SEP 6

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 L. Arnold, Jr.

Licensed Embalmer No. 4667

P. O. Address LEWISTOWN, MO.

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.