

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-028061

STATE FILE NUMBER

AMENDED

Registration District No. 391 Primary Registration District No. 4505 Registrar's No. 18

FILED JUL 18 1961

1. PLACE OF DEATH a. COUNTY <u>STODDARD</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BELL CITY</u>		Length of stay in 1b <u>26 DAYS</u>	c. CITY OR TOWN <u>CHAFFEE</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SHETLEY NURSING HOME</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt. 1-</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>(NMN)</u> Last <u>SMITH</u>			4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1961</u>		
5. SEX <u>MALE</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>AUG. 1, 1890</u>	9. AGE (last birthday) <u>90</u> IF UNDER 1 YEAR: Month <u>7</u> Days <u>-</u> IF UNDER 24 HR: Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER (RET.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and state or country) <u>SIKESTON, MISSOURI</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
14. NAME OF HUSBAND OR WIFE <u>Does Not Apply</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>NONE</u>	
17. INFORMANT <u>ROBERT CAPSHAW - CHAFFEE, 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>Shock</u> DUE TO (b) <u>Circulatory failure</u> DUE TO (c) <u>arteriosclerotic degeneration</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic nephrosis; senility changes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u> <u>3 DAYS</u> <u>1 YEAR</u>	

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.) <u>-</u>	
20c. TIME OF INJURY Hour <u>-</u> a.m. <u>-</u> p.m. <u>-</u>		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.) <u>-</u>	
20f. CITY, TOWN, OR LOCATION <u>-</u>		COUNTY <u>-</u>		STATE <u>-</u>	

21. I attended the deceased from <u>June 1-60</u> to <u>July 1-61</u> and last saw him alive on <u>July 1-61</u> Death occurred at <u>10:00 p</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>L.G. Masters</u>		22b. ADDRESS <u>Chaffee, MO</u>		22c. DATE SIGNED <u>7-61</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>July 2, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>UNION PARK CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>CHAFFEE, Missouri</u>	
24. FUNERAL DIRECTOR <u>DISPLINGHOFF FUNERAL HOME - CHAFFEE, MO.</u>		ADDRESS <u>-</u>		25. DATE RECD. BY LOCAL REG. <u>7/3/61</u>		26. REGISTRAR'S SIGNATURE <u>Bernice Moore</u>	

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

WHERE APPROPRIATE ON THIS RECORD MAKE AS FOLLOWS

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 Jack T. Burnett

Licensed Embalmer No. 4472

P. O. Address Chaffee, 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.