

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035733
STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 323

AMENDED

FILED NOV 13 1961

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Sullivan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		Length of stay in 1b 4 years	c. CITY OR TOWN Green City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Community Nursing Home #2		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) No street address Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Kathryn Middle ----- Last Shoop			4. DATE OF DEATH Month November Day 1 Year 1961		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/10/1885	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and state or country) Shibleys Point, Mo.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Adam Shoop	13b. MOTHER'S MAIDEN NAME Cyrena Shibley	14. NAME OF HUSBAND OR WIFE Never married
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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. None	17. INFORMANT Address Mrs. Glenn Long, Green Castle, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachectic and debilitation weeks		INTERVAL BETWEEN ONSET AND DEATH weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) metastatic malignancy to lungs months	
	DUE TO (c) Primary site of carcinoma unknown	
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"/> N: <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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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
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21. I attended the deceased from **8-16-61** to **November, 1961** and last saw her **alive** on **November 4, 1961**
Death occurred at **6:00 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) George H. Scheurer, D.O.	22b. ADDRESS Kirksville	22c. DATE SIGNED Nov. 4, 1961
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/4/1961	23c. NAME OF CEMETERY OR CREMATORY Green City Cemetery	23d. LOCATION (City, town, or county) (State) Green City, Mo.
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24. FUNERAL DIRECTOR ADDRESS Glenn E. Fontenot, Green City, Mo.	25. DATE RECD. BY LOCAL REG. 11-7, 1961	26. REGISTRAR'S SIGNATURE Doris W. Ratliff
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(Licensed Embalmer's Statement on Reverse Side)

AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

GEORGE H. SCHNEIDER, D.D.

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 Karl R. Kent
Licensed Embalmer No. 4689

P. O. Address Green City, 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.