

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-019394

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 164

Primary Registration District No. 3032

Registrar's No. 76

FILED MAY 28 1962

1. PLACE OF DEATH a. COUNTY <b>Johnson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Johnson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Warrensburg</b>		Length of stay in 1b <b>Life</b>	c. CITY OR TOWN <b>Warrensburg</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Warrensburg Medical Center Inc.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>400 South Holden, Street</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Rosa</b> Middle <b>Blanche</b> Last <b>Shockey</b>			4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>1962</b>
5. SEX <b>Lemale</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-3-71</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9. AGE (last birthday) <b>91</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11a. FATHER'S NAME <b>R.B. Harwood</b>		11b. MOTHER'S MAIDEN NAME <b>Rosa Des Combes</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b> 14. NAME OF HUSBAND OR WIFE <b>Wm. Shockey, Deceased</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Eleanor Shockey, Warrensburg, Mo.</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senility</b>			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) <b>Cholecystitis</b>			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>2-15-57</u> to <u>5-24-62</u> and last saw her alive on <u>5-24-62</u> Death occurred at <u>4:00</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title) <b>M.D.</b>		22b. ADDRESS <b>Warrensburg, Missouri.</b>	22c. DATE SIGNED <b>5-25-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5-26-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Hill</b>	23d. LOCATION (City, town, or county) (State) <b>Warrensburg, Missouri.</b>
24. FUNERAL DIRECTOR <b>Sweeney Phillips, Warrensburg, Mo.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>May 25, 1962</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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Rev. 4/59

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**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 J. Earl Priel

Licensed Embalmer No. 3878

P. O. Address Warrensburg, 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.