

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 20 1950

State File No.

No. 300
10.48

BIRTH NO. _____ REG. DIST. NO. 328 PRIMARY REG. DIST. NO. 6112 Registrar's No. 48

1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ROCKVIEW W</u>		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ROCKVIEW W</u>	
		d. STREET ADDRESS (If rural, give location) <u>Box F D # 2</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>EVERETT</u> b. (Middle) <u>HIRAM</u> c. (Last) <u>SHACKLES</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>DEC 30 1949</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>FEB 27-1885</u>
9. AGE (In years last birthday) <u>64</u> 10. IF UNDER 1 YEAR Months <u>10</u> Days <u>3</u>		11. BIRTHPLACE (State or foreign country) <u>ROSEHILL ILL</u>	
12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
13a. FATHER'S NAME <u>W.M. SHACKLES</u>		13b. MOTHER'S MAIDEN NAME <u>SUSAN WALTER</u>	
13c. NAME OF HUSBAND OR WIFE <u>IVA J. SHACKLES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>497-01-0204</u>	
		17. INFORMANT'S SIGNATURE OR NAME <u>Wm. J. Shackles</u> ADDRESS <u>Rockview</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Coronary Disease</u> ANTECEDENT CAUSES (b) <u>Prof. Coronary Thrombosis</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <u>Sudden Death Nature</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Causes - Ch. Cordac Dis</u>	
		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4201</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/30</u> , 19 <u>49</u> , and that death occurred at <u>12:30</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>W. D. Dunning, M.D.</u>		23b. ADDRESS <u>Chaffee Mo</u>	
23c. DATE SIGNED <u>1/3/50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>1-3-1950</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Rockview Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Rockview Mo</u>	
DATE REC'D BY LOCAL REG. <u>1/3/50</u>		REGISTRAR'S SIGNATURE <u>J.B. MacGregor</u> ADDRESS <u>298</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Hubbs</u>		ADDRESS <u>CHAFFEE MO</u>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED JAN 13 1961
District Health Office, N.Y.C.
District File Number 150-5
Date Filed

JAN 20 1961

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

working under my personal supervision.

Signed.....
Student Embalmer

Signed

Student Embalmer No.

Licensed Embalmer No. 3810

P. O. Address

Cape Girardeau, 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 this body is not embalmed, fact should be so stated above.