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FILED NOV 14 1950THE DIVISION OF HEALTH - MISSOURI  
STANDARD CERTIFICATE OF DEATH34188  
State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>226</u>		PRIMARY REG. DIST. NO. <u>5798</u>		Registrar's No. <u>46</u>	
1. PLACE OF DEATH a. COUNTY <u>Monroe county</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>By</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Paris, Mo</u>		c. LENGTH OF STAY (In this place) <u>6 Yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Shelbina, Mo.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Monroe Co. Home</u>				d. STREET ADDRESS (If rural, give location) <u>X</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Raphael Alonza</u> b. (Middle) <u>Threlkeld</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>10-5-1950</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-23-1869</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>9</u>	IF UNDER 1 YEAR Days <u>12</u>	IF UNDER 2 HRS. Hours Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (State or foreign country) <u>Monroe Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Josiah Threlkeld</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Jane Greenwell</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</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>X</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Frank Threlkeld, Shelbina, Mo.</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>Chronic Myocardial Infarction</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>7.12</u> <u>4.221</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Aug 2, 1950</u> to <u>Oct 5, 1950</u> , that I last saw the deceased alive on <u>8/2/50</u> , and that death occurred at <u>5:15 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. M. Republic M.D.</u>				23b. ADDRESS <u>Shelbina Mo</u>		23c. DATE SIGNED <u>10-31-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10-7-1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>I.B.O.F.</u>		24d. LOCATION (City, town, or county) (State) <u>Shelbina, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>10-31-50</u>		REGISTRAR'S SIGNATURE <u>Anna M. Burkett</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>William-Barkeler, Shelbina, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

Date Received: NOV 3 1950  
DISTRICT HEALTH OFFICE #2  
District File Number 11-56-18  
Date Filed: NOV 6 1950

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 .....  
Student Embalmer

Signed \_\_\_\_\_

*C. W. Hawkins*

Licensed Embalmer No. 3495

P. O. Address Shelburne, VT

The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply constitutes grounds for revocation of license.)

his body is not embalmed, fact should be so stated above.