

FILED MAY 18 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17583

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 30721 Registrar's No. 82

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall		c. LENGTH OF STAY (In this place) 10 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION Fitzgibbon Hospital		e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall	
		f. STREET ADDRESS (If rural, give location) 308 East Lacy	

3. NAME OF DECEASED (Type or Print) a. (First) Ruby b. (Middle) Stith c. (Last) Sheffer			4. DATE OF DEATH (Month) (Day) (Year) May 14, 1954		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 30, 1927	9. AGE (In years last birthday) 26	10. UNDER 1 YEAR Months 7 Days 14	11. BIRTHPLACE (State or foreign country) Arrow Rock, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home					

13a. FATHER'S NAME Wallace Stith	13b. MOTHER'S MAIDEN NAME Lorene Morris	14. NAME OF HUSBAND OR WIFE John Sheffer
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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. 497-24-8054	17. INFORMANT'S SIGNATURE OR NAME John Sheffer	ADDRESS Marshall, Mo.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myelogenous Leukemia		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) m.	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 **April 21, 1954** to **14, 1954**, that I last saw the deceased alive on **14, 1954**, and that death occurred at **10:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Name or title) John R. Lawrence M.D.	23b. ADDRESS Marshall, Mo.	23c. DATE SIGNED 5-15-54
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24a. BURIAL CREMATION REMOVAL (Specify) Burial	24b. DATE May 16, 1954	24c. NAME OF CEMETERY OR CREMATORY Ridge Park Cemetery	24d. LOCATION (City, town, or county) (State) Marshall, Missouri
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DATE REC'D BY LOCAL REG. 5-15-54	REGISTRAR'S SIGNATURE Simon J Gray	FUNERAL DIRECTOR'S SIGNATURE Campbell-Lewis	ADDRESS Marshall, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

972
0

0972
0

2041

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 James H. Lewis Jr.

Licensed Embalmer No. 4709

P. O. Address Missouri, 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.