

FILED SEP 27 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **29803**

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <u>38</u>   |  | PRIMARY REG. DIST. NO. <u>3006</u>  |  | Registrar's No. <u>257</u>  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Boone</u>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u> |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Columbia</u> )  |  | c. LENGTH OF STAY (in this place) <u>0</u> WKS   |  | c. CITY OR TOWN <u>Columbia</u>   |  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Boone County Hospital</u>  |  |  |  | STREET ADDRESS (If rural, give location) <u>1301 Windsor Ave</u> <span style="float: right;"><u>010 J</u><br/><u>0</u></span>             |  |   |  |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Alice</u>   |  | b. (Middle) <u>Marian</u>  |  | c. (Last) <u>Shuck</u>  |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 17 1954</u>   |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>   |  | 8. DATE OF BIRTH <u>1974</u> Sept 13, <del>1970</del>   |  |
| 9. AGE (In years last birthday) <u>80</u>   |  | IF UNDER 1 YEAR Months _____ Days _____  |  | IF UNDER 4 HRS. Hours _____ Min. _____  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY _____  |  | 11. BIRTHPLACE (City and State or Foreign Country) <u>Tipton, Missouri</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |
| 13a. FATHER'S NAME <u>William H. Yontz</u>  |  | 13b. MOTHER'S MAIDEN NAME <u>Squires</u>   |  | 14. NAME OF HUSBAND OR WIFE <u>George Shuck</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. _____  |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Juanita Shuck 1301 Windsor Ave</u>   |  |   |  |
| 18. CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c)<br><i>This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>                      |  |  |  | MEDICAL CERTIFICATION   |  |   |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>  |  |   |  |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> <u>Many yrs</u>   |  |  |  |   |  |   |  |
| DUE TO (c) _____  |  |  |  |   |  |   |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>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"/>  |  | <u>4-200</u>  |  |
| 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) _____   |  | 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>July 1953</u> , to <u>9-17-1954</u> , that I last saw the deceased give up <u>9-17-1954</u> , and that death occurred at <u>6:30 p.m.</u> , from the causes and on the date stated above. |  |  |  |   |  |   |  |
| 23a. SIGNATURE <u>Arthur Walters M.D.</u> (Degree or title)   |  |  |  | 23b. ADDRESS <u>22 N 8th Columbia, Mo</u>   |  | 23c. DATE SIGNED <u>9-17-54</u>   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>  |  | 24b. DATE <u>9-19-1954</u>   |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>  |  | 24d. LOCATION (City, town, or county) (State) <u>Kansas City, Kansas</u>  |  |
| DATE REC'D BY LOCAL REG. <u>Sept 18 1954</u>  |  | REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Parsons Funeral Service, Columbia Mo</u>  |  |   |  |

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

cause of death  
ad. 10/1/54

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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.....

Licensed Embalmer No. *48*.....

P. O. Address *Columb*.....

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.