

FILED DEC 5 - 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **36902**

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>364</u>			
1. PLACE OF DEATH a. COUNTY <u>ADAIR</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Schuyler</u>					
b. CITY (If outside corporate limits, write RURAL and give town) <u>Hicksville Mo</u>		c. LENGTH OF STAY (in this place) <u>1 mo.</u>		c. CITY OR TOWN <u>Rural</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>MCH</u>				e. STREET ADDRESS (If rural, give location) <u>Rural W Prairie</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Josie</u> b. (Middle) <u>Frances</u> c. (Last) <u>Shacklett</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 27 56</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW</u>		8. DATE OF BIRTH <u>AUG 1, 1874</u>			
9. AGE (In years last birthday) <u>82</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>29</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>					
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 <u>Housewife</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Schuyler Co Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>John Oliver</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Mithel</u>		14. NAME OF HUSBAND OR WIFE <u>John Shacklett deceased</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Clare Burnett</u> ADDRESS <u>Lancaster 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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Peripheral Circulatory Collapse</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>inanition &amp; asthenia</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>24 hrs</u>  <u>yes</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) _____		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>11-5</u> , 19 <u>56</u> , to <u>11-27</u> , 19 <u>56</u> that I last saw the deceased alive on <u>11-27</u> , 19 <u>56</u> and that death occurred at <u>1:32 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Wm B. Reed</u>			(Degree or title) <u>DR</u>		23b. ADDRESS <u>Kidman Mo</u>		23c. DATE SIGNED <u>11-27-56</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov 29 56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Timothy</u>		24d. LOCATION (City, town, or county) (State) <u>Schuyler Co Mo</u>			
DATE REC'D BY LOCAL REG. <u>11-30-56</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Morehead Norman Lancaster Mo</u> ADDRESS _____					

(Licensed Embalmer's Statement on Reverse Side)

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

Mo. 300  
10.48

Permanently

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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..... *Noval E. Foster*.....

Licensed Embalmer No. *4742*

P. O. Address *Fukonville*.....

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.