

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 5 - 1957

 State File No. 8416
 Registrar's No. 055

BIRTH NO. _____		REG. DIST. NO. <u>132</u>		PRIMARY REG. DIST. NO. <u>4203</u>		State File No. <u>8416</u>		Registrar's No. <u>055</u>						
1. PLACE OF DEATH a. COUNTY <u>Grundy</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Grundy</u>										
b. CITY OR TOWN <u>Galt</u>		c. LENGTH OF STAY (in this place) <u>Life</u>		c. CITY OR TOWN <u>Galt 6408</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 _____				e. STREET ADDRESS (If rural, give location) _____										
3. NAME OF DECEASED (Type or Print) <u>ALICE</u>			a. (First)			b. (Middle) <u>RHAEN</u>			c. (Last) <u>SHOCKEY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>3-29-1957</u>		
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED/NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct 11 1887</u>		9. AGE (In years last birthday) <u>69</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>Humphreys Mo.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13a. FATHER'S NAME <u>Martin Johnson</u>				13b. MOTHER'S MAIDEN NAME <u>Jane Brown</u>				14. NAME OF HUSBAND OR WIFE <u>Joseph H Shocke</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>500-07-4320</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Joseph H Shocke</u>				ADDRESS <u>Galt 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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Medicine Coronary Occlusion</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Myocardial</u> <u>3 years</u> DUE TO (c) <u>Hypertension & Nephritis</u> <u>3-4 years</u> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO <input 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) <u>59.3X</u>								
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		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>July</u> , 19 <u>50</u> , to <u>March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-29-57</u> , and that death occurred at <u>12:30 p.m.</u> , from the causes and on the date stated above.														
23a. SIGNATURE <u>A. W. Fair</u> (Doctor or title) <u>2</u>						23b. ADDRESS <u>Galt Mo</u>			23c. DATE SIGNED <u>3/30/59</u>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-2-57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Galt Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Galt Mo</u>								
DATE REC'D BY LOCAL REG. <u>4-2-57</u>		REGISTRAR'S SIGNATURE <u>Drene Fair</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>DK Payne</u> ADDRESS <u>Galt Mo</u>								

(Licensed Embalmer's Statement on Reverse Side)

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

APR 8 1957

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 *PA Payne Jr*
Licensed Embalmer No. *340*

P. O. Address *Galt*

**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.**