

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16079

State File No. \_\_\_\_\_

FILED JUN 4 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 4 PRIMARY REG. DIST. NO. 4015 Registrar's No. 53

1. PLACE OF DEATH a. COUNTY <b>Atchison</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before death) a. STATE <b>Missouri</b> b. COUNTY <b>Atchison</b>	
b. CITY OR TOWN <b>Westboro</b>		c. CITY OR TOWN <b>Westboro</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION:		STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) <b>Charles Shough</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>May-6-1957</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Wh</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Filling Station Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>					

13a. FATHER'S NAME <b>Micheal Shough</b>		13b. MOTHER'S MAIDEN NAME <b>Miranda Crockett</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY (If yes, give war or dates of service) <b>662-26-2013</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mary Deane St. Joseph Mo</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary occlusion</b>		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <b>Arterio-sclerotic cardio-vascular disease</b>	
				DUE TO (c) <b>disease</b>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>4201</b>		20. AUTOPSY? <b>2</b> 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) (Min.)		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 2/6/51, 1951, to 5/6/57, 1957, that I last saw the deceased alive on 5/5/57, 1957, and that death occurred at 4:00 p. m., from the causes and on the date stated above.

23a. SIGNATURE <b>W. H. Meade Meyer</b>		23b. ADDRESS <b>Yonkers Mo.</b>		23c. DATE SIGNED <b>5/8/57</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>5-8-1957</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Senter Grove</b>	
24d. LOCATION (City, town, or county) (State) <b>Westboro, Mo</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Westboro, Mo</b>			

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE **May 31, 1957** **Harwin Schaefer** **Westboro, Mo**

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

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(Licensed Embalmer's Statement on Reverse Side)

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 Ashley R. Tucker, Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Ashley R. Tucker  
Licensed Embalmer No. 4757

P. O. Address Westboro, Ma

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.