

STANDARD CERTIFICATE OF DEATH

State File No. **19899**

FILED MAY 27 1957

BIRTH MO. \_\_\_\_\_ REG. DIST. NO. **375** PRIMARY REG. DIST. NO. **6279** Registrar's No. **8**

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WRIGHT</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Mo</b> b. COUNTY <b>WRIGHT</b> |   |
| b. CITY (If outside corporate limits, write RURAL and give township) <b>RURAL (Gasconade)</b> |  | c. CITY OR TOWN   | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. LENGTH OF STAY (in this place) <b>years</b>  |  | e. STREET ADDRESS (If rural, give location) <b>RURAH PTS, No 02 Mansfield 11700</b>   |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Gasconade Hosp.</b>                                |  |   |   |

|   |             |  |  |
|---|-------------|--|--|
| 3. NAME OF DECEASED (Type or Print) <b>Tennessee BROWN PLASTER</b>  |             | 4. DATE OF DEATH (Month) (Day) (Year) <b>4-16-57</b> |  |
| a. (First)  | b. (Middle) | c. (Last)  |  |
| 5. SEX <b>F.</b>  |             | 6. COLOR OR RACE <b>W.</b>                           |  |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>   |             | 8. DATE OF BIRTH <b>9-12-1875</b>                    |  |
| 9. AGE (In years last birthday) <b>82</b>   |             | IF UNDER 1 YEAR Months <b>7</b>                      | IF UNDER 24 HRS. Days <b>4</b> Hours <b>4</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b> |             | 10b. KIND OF BUSINESS OR INDUSTRY                    |  |
| 11. BIRTHPLACE (City and State or Foreign Country) <b>WRIGHT Co. Mo.</b>                                      |             | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>           |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 13a. FATHER'S NAME <b>George W. Shackelford</b>  |  | 13b. MOTHER'S MAIDEN NAME <b>CLOY Shackelford</b> |  | 14. NAME OF HUSBAND OR WIFE <b>SAM. PLASTER</b>                            |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> |  | 16. SOCIAL SECURITY NO. <b>None</b>               |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Lloyd Brown Mansfield, Mo</b> |  |

|   |   |   |   |
|---|---|---|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Arteriosclerosis</b>   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Not known</b><br><b>12-15-56</b> |
|   | ANTECEDENT CAUSES<br><b>Hypertension, Arteriosclerosis</b>  |   |   |
|   | MORBID CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last.<br><b>Due to (b) Endarteritis obliterans, (2 feet)</b> |   |   |
| 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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 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) (Minute)   |  | 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 <b>June</b> , 19 <b>56</b> , to <b>4-16-</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4-4-</b> , 19 <b>57</b> , and that death occurred at _____ m., from the causes and on the date stated above. |  |  |  |                            |  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 23a. SIGNATURE <b>Sell Cowen</b> (Degree or title)                           |  | 23b. ADDRESS <b>Mo Mountain Grove Mo</b> |  | 23c. DATE SIGNED <b>4-30-57</b>                   |  |
| 24a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>                        |  | 24b. DATE <b>4-21-57</b>                 |  | 24c. NAME OF CEMETERY OR CREMATORY <b>CURTISE</b> |  |
| 24d. LOCATION (City, town, or county) (State) <b>N.W. WARWOOD WRIGHT MO.</b> |  |  |  |   |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| DATE REC'D BY LOCAL REG. <b>5-18-1957</b> |  | REGISTRAR'S SIGNATURE <b>Bennie J. Jones</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John Simpson Hartsville Mo</b> |  |
|---|--|--|--|--|--|

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED  
 WRIGHT CO. HEALTH DEPT.  
 5-18-57  
 637-57  
 County File Number  
 Date Filed

**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..... *Bill Barber*

Licensed Embalmer No. 384

P. O. Address *Wright Co. Health Dept.*

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.