FILED AUG 8 1957

STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 25340

Registration District No. 200 Primary Registration District No. 5726 Registrar's No. 117

1. PLACE OF DEATH
a. COUNTY: Macon
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Middle Fork — Inside Limits: Yes ☐ No ☑
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: R.F.D. Excello — Length of stay in Hospital: Yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Macon
c. CITY OR TOWN: Excello, Mo. — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): Middle Fork Twp. — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First John Middle O. Last Shockey

4. DATE OF DEATH: Month July Day 25 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 24, 1862

9. AGE (In years last birthday): 95 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: No.

11. BIRTHPLACE (City and state or country): Williamsport, Pa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: C.W. Shockey

14. MOTHER'S MAIDEN NAME: Anna Hoover

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: No.

17. INFORMANT: Walter Shockey — Address: Excello, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — 2 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Cerebral Arteriosclerosis
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 4200

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Sept. 1956, to July 25 '57 and last saw her/him alive on July 25
Death occurred at 7:20 A.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: James E. Campbell (Degree or title) MD — **22b. ADDRESS**: Macon Mo. — **22c. DATE SIGNED**: 7/30/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **23b. DATE**: July 27, 57 — **23c. NAME OF CEMETERY OR CREMATORY**: Fairview Cem. — **23d. LOCATION** (City, town, or county) (State): R.F.D. Excello Mo.

24. FUNERAL DIRECTOR: Lester Hutton — **ADDRESS**: Macon, Mo — **25. DATE REC'D BY LOCAL REG.**: 8/1/57 — **26. REGISTRAR'S SIGNATURE**: Ruth McNeely

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

85

County 8-67-119

Date Filed 8-7-67

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Charles L. Hutt

Licensed Embalmer No. 4

P. O. Address Maco

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.