

Dept. Health,  
Inc., & Welfare  
S. Public  
Health Service

FILED DEC 9 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39022  
STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 413

V. S. 300  
Rev. 1-57 0

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Shelby</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Kirksville</b> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR <b>Shelbina</b> TOWN
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>Laughlin Hosp.</b> INSTITUTION		Length of stay in 1b <b>2 Hours</b>	d. STREET ADDRESS (If outside, give location) <input type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Myrtle (none) Furnish</b>			4. DATE OF DEATH Month Day Year <b>Nov. 23, 1957</b>	
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 17, 1885</b>	9. AGE (In years last birthday) <b>72</b>	10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Monroe County, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John Frank Million</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth K. Thacker</b>	14. NAME OF HUSBAND OR WIFE <b>John Monroe Furnish</b>
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15. WAS DECEASED EVER IN U. S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mr. John M. Furnish, Shelbina, Mo.</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____ <b>4201</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ p.m.	

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	20f. CITY, TOWN, OR LOCATION _____	COUNTY _____	STATE _____
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21. I attended the deceased from **Nov. 23, 1957** to **Nov. 23, 1957** and last saw her alive on **Nov. 23, 1957**  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>A. T. Roads, Jr.</b>	(Death or title) <b>Dr. Kirksville, Mo</b>	22b. ADDRESS <b>11-26-57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/26/1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Shelbina Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Shelbina, Missouri</b>
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24. FUNERAL DIRECTOR <b>Hayes Funeral Home, Shelbina, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>12-4-1957</b>	26. REGISTRAR'S SIGNATURE <b>Doris W. Rattleff</b>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *Paul E. Hayes* .....

Licensed Embalmer No. 4461 .....  
P. O. Address Shelbina, Mo. .....

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.