

FILED NOV 25 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40147

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 5551 Registrar's No. 37

S. 300
v. 1-57/1

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

3. NAME OF DECEASED (Type or print) First <u>Oscar A</u> Middle <u>Shoberg</u> Last <u>Shoberg</u>			4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>57</u>		
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/4-1877</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and state or country) <u>Union Co., S. Dak.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Wm Shoberg</u>	13b. MOTHER'S MAIDEN NAME <u>Cooper</u>	14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT <u>Wm Shoberg, West Plains Mo</u> Address <u></u>
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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) <u>Cardio-Vascular Accident</u> <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u>Terminal Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4221</u>		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.)
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20c. TIME OF INJURY Hour <u></u> Month, Day, Year a.m. <u></u> p.m. <u></u>	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 <u>31 Oct 57</u> to <u>10 Nov 57</u> and last saw him alive on <u>31 Oct 1957</u> Death occurred at <u>4: P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>[Signature]</u>	22b. ADDRESS <u>West Plains, Mo</u>	22c. DATE SIGNED <u>21-11-57</u>
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23a. BURIAL CREMATION, REMOVAL (Specify) <u></u>	23b. DATE <u>11/13-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Doneland</u>	23d. LOCATION (City, town, or county) (State) <u>West Plains, Mo</u>
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24. FUNERAL DIRECTOR <u>Laborers West Plains Mo</u>	25. DATE RECD. BY LOCAL REG. <u>11-23-57</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>
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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 *H. H. Roberts*

Licensed Embalmer No. *3437*

P. O. Address *West Plains*

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.