

FILED DEC 23 1957

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 455

S. 300  
ev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Roone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ralls</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Perry</u> OR TOWN <u>0870</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. University</u> Length of stay in lb <u>2 day</u>		d. STREET ADDRESS <u>Route 3</u> (If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Shinn</u> First <u>Tamera</u> Middle <u>Ann</u> Last <u>Shinn</u>		4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>3 days</u> IF UNDER 1 YEAR: Months <u>3</u> Days <u>17</u> Hours <u>30</u> IF UNDER 24 HRS. Min.
11. BIRTHPLACE (City and state or country) <u>Mexico, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <u>ODESSA SHINN</u>	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Chart Medical Center</u>		Address	
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>PREVIABLE PREMATURE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>UNKNOWN CAUSE</u> DUE TO (c) <u>(AUTOPSY REVEALED NO CAUSE OF DEATH)</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>776x</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT WORK <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
21. I attended the deceased from <u>2-6-57</u> to <u>12-8-57</u> and last saw her/him alive on <u>12-8-57</u> Death occurred at <u>6:00 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Walter Ray Stegner Jr M.D.</u> (Degree or title)		22b. ADDRESS <u>MEDICAL CENTER, U of Mo, Columbia</u>	
22c. DATE SIGNED <u>12-12-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE <u>December 13, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Univ. of Missouri</u>	23d. LOCATION (City, town, or county) (State) <u>Columbia, Missouri</u>
24. FUNERAL DIRECTOR <u>VINCENT P. PERNA M.D.</u> ADDRESS <u>Univ of Mo. Columbia</u>		25. DATE RECD. BY LOCAL REG. <u>Dec 14 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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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 <sup>cremated</sup> ~~embalmed~~

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

working under my personal supervision.

Student .....

Signature of Student Embalmer

Signed Vincent P. Perma, M.P. .....

3 Licensed Embalmer No. ....

P. O. Address .....

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.