

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035203

STATE FILE NUMBER

FILED OCT 7 1958

Registration District No. 336 Primary Registration District No. 6170 Registrar's No. 467

| | | | | | |
|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Shannon</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Michigan</u> b. COUNTY <u>Jackson</u> | | |
| b. CITY OR TOWN <u>Bartlett</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Springport</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>Webbs Cabins</u> | | Length of stay in 1b <u>hours</u> | d. STREET ADDRESS (If outside, give location) <u>Rural Route 2</u> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Riley</u> Last <u>Starks</u> | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>10</u> Year <u>1958</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 12, 1875</u> | 9. AGE (In years last birthday) <u>82</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> |
| 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 <u>Farm</u> | 11. BIRTHPLACE (City and state or country) <u>Michigan</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>Gode C. Starks</u> | | 13b. MOTHER'S MAIDEN NAME <u>Emma Williams</u> | | 14. NAME OF HUSBAND OR WIFE <u>Divorced</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | 17. INFORMANT <u>Mrs. Jean Rocky, Springport, Mich.</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>Shot gun wound via mouth</u> <u>2 top of skull shattered</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>976X</u> DUE TO (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> |
| 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 checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Self inflicted shot gun - muzzle in mouth</u> | | | |
| 20c. TIME OF INJURY <u>7:40 p.m.</u> | | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Motell -</u> | | | |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 20f. CITY, TOWN, OR LOCATION <u>Bartlett Sta. Shannon Mo</u> | | COUNTY | STATE |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>7:40 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22b. SIGNATURE <u>Dr. Angus F. Williams, County Coroner</u> | | | 22b. ADDRESS <u>Emmerson Mo</u> | | 22c. DATE SIGNED <u>9-24-58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> | | 23b. DATE <u>9/16/58</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calince Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Springport, Mich.</u> |
| 24. FUNERAL DIRECTOR <u>Kerwin Funeral Chapel, SPort, Mich</u> | | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>Oct 6 1958</u> | 26. REGISTRAR'S SIGNATURE <u>Mabel Green</u> | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

AS61 03 130

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

Richard A. Norton

Licensed Embalmer No. 5029

P. O. Address. Mtn. View, N.J.

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.