

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008273

STATE FILE NUMBER

FILED MAR 30 1959

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 97

300
-57

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1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Adair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kirksville ⁰⁰¹³⁰ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION C.N.H. #2		Length of stay in lb yrs.	d. STREET ADDRESS (If outside, give location) 410 S Elson St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) WILLIAM EDWARD SHAIN			4. DATE OF DEATH Month March Day 18 Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1878
9. AGE (In years last birthday) 80		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) Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining	11. BIRTHPLACE (City and state or country) 0 Macon County, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME A. A. Shain	
13b. MOTHER'S MAIDEN NAME Angeline Thurman		14. NAME OF HUSBAND OR WIFE Nellie (Fox) Shain(D)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Ralph Shain, Kirksville, Missouri		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) Cachexia of debilitation DUE TO (b) Squamous Cell Carcinoma of lower 1/3 esophagus Mouth DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH weeks
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 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 _____ 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 1-30-59 to 3-18-59 and last saw him alive on 3-18-59 Death occurred at 5:36 A. M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or title) George H. Schauer, D.O.		22b. ADDRESS Kirksville, Mo.	22c. DATE SIGNED 3-20-59
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 3-20-1959	23c. NAME OF CEMETERY OR CREMATORY Novinger Cemetery
23d. LOCATION (City, town, or county) Novinger, Missouri		(State)	
24. FUNERAL DIRECTOR Davis & Davis, Kirksville, Mo.		25. DATE RECD. BY LOCAL REG. 3-23-1959	26. REGISTRAR'S SIGNATURE Doris W. Rutloff

GEORGE H. SCHAUER, D.O.
MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.

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 *Robert B. Davis*

Licensed Embalmer No. 4219

P. O. Address Kirksville, 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.