

MORTUARY DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

REG. JUL 13 1959

59-020279
STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 201

1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Adair</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>			Length of stay in 1b		c. CITY OR TOWN <u>Novinger</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>K. O. H</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>City of Novinger</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Kevin</u> Middle <u>Shockey</u> Last				4. DATE OF DEATH July 4, 1959 Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>7/25/56</u>	9. AGE (last birthday) <u>2</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>		11. BIRTHPLACE (City and state or country) <u>Kirksville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <u>Vera Crist Shockey</u>		14. NAME OF HUSBAND OR WIFE <u>X</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 Address <u>Vera Shockey Phillips, Novinger, Mo</u>			
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>Shock due to trauma</u> <u>Multiple lacerations from dog bites</u> DUE TO (b) <u>Purported dog bites</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Multiple lacerations from dog bites</u>					
20c. TIME OF INJURY Hour <u>7:35</u> Month, Day, Year <u>7-3-59</u> p.m. <u>Alley behind home</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Novinger, Mo</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Novinger Adair Mo.</u>	
21. I attended the deceased from <u>7-3-59</u> to <u>7-3-59</u> and last saw him alive on <u>7-3-59</u> Death occurred at <u>1:55 A.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>Addresson Howler Jr</u>				22b. ADDRESS <u>Kirksville, Mo.</u>		22c. DATE SIGNED <u>7-6-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7/6/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Owney Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Adair County, Mo.</u>		
24. FUNERAL DIRECTOR <u>Carl M. [Signature]</u>			ADDRESS <u>Kirksville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-6-1959</u>	26. REGISTRAR'S SIGNATURE <u>David W. Rathoff</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

George W. Davis

Licensed Embalmer No. 4799

P. O. Address Kingsville

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.