

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED JUL 16 1959

59-024437

STATE FILE NUMBER

Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 125

| | | | | | | | | |
|--|--|---|--|--|--|--|---|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Cass</u> | | | | 2. USUAL RESIDENCE (Where deceased lived.) If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Harrisonville</u> | | Length of stay in, lb <u>30 min</u> | | c. CITY OR TOWN <u>Rural Dayton Twp.</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>Memorial Hospital</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ROXIE SHIELDS FANSLER</u> | | | | 4. DATE OF DEATH Month Day Year <u>July 9 1959</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb 2 1902</u> | 9. AGE (last birthday) <u>57</u> | | 10. UNDER 1 YEAR Months Days | 11. IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/> | | 11. BIRTHPLACE (City and state or country) <u>Waldron Mo. U.S.A</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u> | |
| 13a. FATHER'S NAME <u>Marion Arthur Shields</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Lucie Belle Veatch</u> | | 14. NAME OF HUSBAND OR WIFE <u>J. F. Fansler</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>489-24-1308</u> | | 17. INFORMANT <u>B. J. SMITH 4024 E 70TH TERR ^{KC} MO</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> | | | | | | | <u>3 am</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Atherosclerosis</u> | | | | | | | <u>5 yrs</u> | |
| DUE TO (c) <u>Coeliac Insufficiency</u> | | | | | | | <u>5 yr</u> | |
| 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 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>May 27 1957</u> to <u>July 9, 1959</u> and last saw her alive on <u>July 9, 1959</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>A. E. Kurch M.D.</u> | | | | 22b. ADDRESS <u>Harrisonville, Mo</u> | | | 22c. DATE SIGNED <u>July 11, 1959</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>July 12 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Orient Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Harrisonville Mo.</u> | | | | |
| 24. FUNERAL DIRECTOR <u>Remminger's Harrisonville, Mo</u> | | | ADDRESS <u>7-12 1959</u> | | 25. DATE RECD. BY LOCAL REG. <u>7-12 1959</u> | | 26. REGISTRAR'S SIGNATURE <u>Mrs Ray Sebee</u> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 23 1959

JUL 29 1959

VS JUN 27 1960

NOV 12 1959

VS MAY 10 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James R Phillip

Licensed Embalmer No. 4641

P. O. Address Harrisonville

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.