

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025810

FILED VS AUG 4 1959

Registration District No. 175 Primary Registration District No. 4275 Registrar's No. 72

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Webster</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marionville</u>		Length of stay in 1b <u>6 yrs.</u>		c. CITY OR TOWN <u>Niangua</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>Methodist Home Aged</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) -----		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle ----- Last <u>Shook</u>				4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1959</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8-26-1877</u>		9. AGE (last birthday) <u>81</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Marshfield, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>George Goodnight</u>				13b. MOTHER'S MAIDEN NAME <u>Melvina ?</u>				14. NAME OF HUSBAND OR WIFE <u>R. M. Shook (Dec.)</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>Willie Hood-Springfield, 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>Myocardial Decompensation</u> DUE TO (b) <u>Lobar Pneumonia</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>Yrs.</u> <u>4 Weeks</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 a.m. p.m.		Month, Day, Year											
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>3-9-57</u> to <u>7-22-59</u> and last saw her alive on <u>7-18-59</u> Death occurred at <u>9:00 a.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Wm Dean Schmidt Sr.</u> (Degree or title)						22b. ADDRESS <u>Marionville, Mo.</u>			22c. DATE SIGNED <u>7-27-59</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-24-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Niangua Cemetery</u>		23d. LOCATION (City, town, or county) <u>Niangua Missouri</u>		(State)					
24. FUNERAL DIRECTOR <u>Rex Rainey-Springfield, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>7-29-1959</u>		26. REGISTRAR'S SIGNATURE <u>Dra Ma Nath</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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ray Lawrence

Licensed Embalmer No. 3312

P. O. Address Springfield,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.