

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS SEP 8 1959

59-028018

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 002 Registrar's No. 3019 50

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Andrew County Missouri</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson Township</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Worth</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Shadey Lawn Nursing Home</u>		Length of stay in 1b <u>6 months</u>		c. CITY OR TOWN <u>Grant City Missouri</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>305 West 5 St.</u>		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>Eva</u>		Middle <u>Pearl</u>		Last <u>Shipley</u>		Month <u>July</u> Day <u>28</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 checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug-29-1879</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR <u>10</u> Months	IF UNDER 24 HR <u>28</u> Days	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housekeeper</u>		11. BIRTHPLACE (City and state or country) <u>Worth County Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Robert N. Shipley</u>			13b. MOTHER'S MAIDEN NAME <u>Susan F. Brown</u>			14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (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 Norma Fluke Bedford Iowa</u> Address <u></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>Arteriosclerotic Cardiovascular Disease</u>		<u>15yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
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 checked="" 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 1946 to 1959 and last saw her/him alive on 6/25/59
 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Frank B Matteson M D</u> (Degree or title)	22b. ADDRESS <u>Grant City, Mo</u>	22c. DATE SIGNED <u>JULY 30/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 30-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Leadona Cemetery Leadona</u>
23d. LOCATION (City, town, or county) <u>Mo</u>	23e. DATE RECD. BY LOCAL REG. <u>8-28-59</u>	23f. REGISTRAR'S SIGNATURE <u>William Sparks</u>
24. FUNERAL DIRECTOR <u>John Anderson Grant City Mo</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>8-28-59</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 John Andrews, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John Andrews

Licensed Embalmer No. 4211

P. O. Address Grant City

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: