

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031275

FILLED VS AUG 18 1959

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 175

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Vernon		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Vernon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Nevada		Length of stay in 1b 3 weeks	c. CITY OR TOWN Stotesbury
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Nevada Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) One

3. NAME OF DECEASED (Type or print) First Middle Last Clara Shackelford			4. DATE OF DEATH Month Day Year August 7, 1959	
--	--	--	---	--

5. SEX Female	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	9. AGE (last birthday) 93	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) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Kansas	12. CITIZEN OF WHAT COUNTRY USA
---	--	---	---

13a. FATHER'S NAME William Kaufmann	13b. MOTHER'S MAIDEN NAME Margaret Clivo	14. NAME OF HUSBAND OR WIFE Augustus B. Shackelford
---	--	---

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. None	17. INFORMANT Address Mrs. Howard Stibut - t. Scott, Kansas
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH unknown
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) Subtrochanteric fracture, left hip	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.) Fell
---	---	---

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 7-19-59

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.) in Home	20f. CITY, TOWN, OR LOCATION Stotesbury	COUNTY Mo.	STATE
---	--	---	----------------------	-------

21. I attended the deceased from Jul 19, 1959 to Aug 7, 1959 and last saw her alive on Aug 7, 1959 Death occurred at 8:20 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <i>Ray W. Kearney MD</i>	22b. ADDRESS Moore Building, Nevada, Mo.	22c. DATE SIGNED 8-11-59
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-7-1959	23c. NAME OF CEMETERY OR CREMATORY Livor poor Cemetery	23d. LOCATION (City, town, or county) (State) Ft. Scott, Kansas
---	------------------------------	--	---

24. FUNERAL DIRECTOR Monantz Mortuary - Ft. Scott, Kansas	25. DATE RECD. BY LOCAL REG. 8-11-1959	26. REGISTRAR'S SIGNATURE <i>Anna E. Jurek</i>
---	--	---

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  _____

Licensed Embalmer No. 4921

P. O. Address Box 5000, Fair

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.