

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006560

FILED VS. FEB 23 1960 149

752

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 752

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Macon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City	Length of stay in 1b 4 days	c. CITY OR TOWN Macon	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 212 Jackson
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First FRANCES Middle SHALE Last SHALE			4. DATE OF DEATH Month Feb Day 4 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-1-08	9. AGE (last birthday) 51	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) Dental Assistant		10b. KIND OF BUSINESS OR INDUSTRY Dr. C. R. Shale		11. BIRTHPLACE (City and state or country) Macon, Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME L. D. Williams		13b. MOTHER'S MAIDEN NAME Carletta Cunningham		14. NAME OF HUSBAND OR WIFE Dr. C. R. Shale		
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. ---		17. INFORMANT Address Dr. C. R. Shale, Macon, Mo.		

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) Diffuse Brain Damage		3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Basal Skull Fracture	3 days
	DUE TO (c) Trauma	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None		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	
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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.) Fall in Hotel Phillips, K. C., Mo.	
20c. TIME OF INJURY Hour 11 a.m. p.m. Month, Day, Year Feb 1, 1960			

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.) Hotel Phillips, K. C., Mo.	20f. CITY, TOWN, OR LOCATION Kansas City	COUNTY Jackson	STATE Mo
21. I attended the deceased from Feb 1, 1960 to Feb. 4, 1960 and last seen per alive on Feb. 4, 1960 Death occurred at 11 A m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) Morgan U. Stockwell, M.D.		22b. ADDRESS 2500 Johnson Dr., K. C. 3, Ks		22c. DATE SIGNED 2-4-60	
23b. DATE Feb. 7, 1960	23c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery		23d. LOCATION (City, town, or county) (State) Macon, Missouri		
24. FUNERAL DIRECTOR Melody-McGilley-Eylar Funeral Home Woodland-Linwood		25. DATE RECD. BY LOCAL REG. 2-8-60	26. REGISTRAR'S SIGNATURE Morgan U. Stockwell		

DOCUMENT

BY AFFIDAVIT OF Morgan U. Stockwell, M.D. MEDICAL CERTIFICATION

VS
DEC 1 1962

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. 490

P. O. Address

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