

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-022910

D VS JUN 20 1960
 ENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 65012 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>	Length of stay in 1b <u>7 da.</u>	c. CITY OR TOWN <u>Springfield</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>Burge Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>C E. Sunshine & Oak Grove</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>KATHERINE</u> Middle <u>SNADON</u> Last <u>Shadon</u>		4. DATE OF DEATH <u>June</u> Month <u>6</u> Day <u>8</u> Year <u>1960</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>10-31-1876</u>
9. AGE (last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>8</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City and state or country) <u>Carrollton Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>James M. Wray</u>	

13b. MOTHER'S MAIDEN NAME <u>Abmira Polward</u>		14. NAME OF HUSBAND OR WIFE <u>John A. Shadon</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>Mrs Abmira Probst</u>		Address <u>917 1/2 S. Luster Springfield 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>Pneumonia, hypostatic</u>		<u>1 wk.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral hemorrhage</u>	<u>10 days.</u>
	DUE TO (c) <u>Hypertensive C-V-R disease</u>	<u></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	
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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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>	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 29 May 60 to 8 June 60 and last saw her alive on 8 June 60
 Death occurred at 8:55 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Samuel E. Fratt, M.D.</u>	22b. ADDRESS <u>1630 N. Jefferson</u>	22c. DATE SIGNED <u>10 June 60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6-11-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pennsboro</u>	23d. LOCATION (City, town, or county) (State) <u>N of Miller Mo</u>
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24. FUNERAL DIRECTOR <u>Morris - Senior</u> ADDRESS <u>Miller Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>6-13-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Meeton</u>
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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 E. P. Seiman

Licensed Embalmer No. 3297

P. O. Address Miller Mo

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.