

Dr. Greene
RIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-031352

STATE FILE NUMBER

FILED VS SEP 8 1960

209 Primary Registration District No. 3043 Registrar's No. 349

1. PLACE OF DEATH a. COUNTY Marion				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Marion					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal		Length of stay in 1b		c. CITY OR TOWN Hannibal		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Elizabeth Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1516 Robinson Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Jasper Middle Lewis Last Shuck				4. DATE OF DEATH Month 8 Day 24 Year 1960					
5. SEX Male	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 1/17/1876	9. AGE (last birthday) 84	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter-Retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Pike Co., Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME John Shuck			13b. MOTHER'S MAIDEN NAME Mecie Clark			14. NAME OF HUSBAND OR WIFE Viva Shuck			
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 Robert Shuck, Hannibal, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Art. Thrombosis.							INTERVAL BETWEEN ONSET AND DEATH 12 days		
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) Myocardial infarction						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 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.)						
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 8-12-60 to 8-24-60 and last saw him alive on 8-24-60 Death occurred at 11:55 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>J. L. Brown</i> (Degree or title)				22b. ADDRESS M.D. 100 N. Sixth, Hannibal, Mo.			22c. DATE SIGNED 8-29-60		
23a. BURIAL-CREATION, REMOVAL (Specify) Burial	23b. DATE 8-26-60	23c. NAME OF CEMETERY OR CREMATORY Grand View Burial Park Hannibal, Mo.			23d. LOCATION (City, town, or county) (State)				
24. FUNERAL DIRECTOR ADDRESS H.M.O'Donnell, Hannibal, Mo.				25. DATE RECD. BY LOCAL REG. 8/31/60		26. REGISTRAR'S SIGNATURE <i>Dr. E. M. Lucke by William M. Norman</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 Clyde. Wick

Licensed Embalmer No. 382

P. O. Address Peru, Pa.

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