

FEDERAL BUREAU OF INVESTIGATION
 FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031625

FILED VS AUG 23 1960

STATE FILE NUMBER

ENDED

Registration District No. 280 Primary Registration District No. _____ Registrar's No. 64

1. PLACE OF DEATH a. COUNTY <u>Platt</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Platt</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Parkville</u>		c. CITY OR TOWN <u>Parkville</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RT. #5 Box 434</u>		d. STREET ADDRESS (If outside, give location) <u>RT. #5 Box 434</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>B.</u> Last <u>Shaver</u>			4. DATE OF DEATH Month <u>August</u> Day <u>4</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>4/25/1885</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (City and state or country) <u>Bruning, Nebraska</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>William Orth</u>		13b. MOTHER'S MAIDEN NAME <u>Clara Kinsley</u>		14. NAME OF HUSBAND OR WIFE <u>Floyd M. Shaver</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>Floyd M. Shaver</u> Address <u>Parkville, Mo.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>
DUE TO (b) <u>Arteriosclerotic Heart disease</u>		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>cells found in fluid. ascites with malignant primary not located.</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		

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 <u>June 24 1960</u> to <u>Aug. 4 1960</u> and last saw him alive on <u>Aug 4 1960</u> Death occurred at <u>2 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>James M. Gernick MD</u>	22b. ADDRESS <u>4030 N Oak KC 16 Mo</u>	22c. DATE SIGNED <u>8-5-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>8/8/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>East Slope Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Platt County, Missouri</u>
24. FUNERAL DIRECTOR <u>H. A. Fulton</u> ADDRESS <u>K. C. Kansas</u>		25. DATE RECD. BY LOCAL REG. <u>8.8.1960</u>	26. REGISTRAR'S SIGNATURE <u>Alphia Rollins</u>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS AUG 24 1960

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 Ralph F. [Signature]

Licensed Embalmer No. 303

P. O. Address K C K

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.