

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033686

FILED VS OCT 11 1960

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 298

ENDED

1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkville</u>		Length of stay in 1b		c. CITY OR TOWN <u>Kirkville</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>Grim-Smith Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1024 N. Edgar</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>Mae</u> Last <u>Sholly</u>				4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>1960</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>4-9-12</u>		9. AGE (last birthday) <u>48</u>		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) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Milan, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>America</u>					
13a. FATHER'S NAME <u>George W. Glendewell</u>				13b. MOTHER'S MAIDEN NAME <u>Hester Bell Potts</u>				14. NAME OF HUSBAND OR WIFE <u>Albert Francis Sholly</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>496-36-7938</u>		17. INFORMANT Address <u>Hospital Record Kirkville, 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>Acute hemorrhagic pancreatitis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
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) <u>Chronic cholecystitis</u>								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 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 _____ 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 <u>Sept 1948</u> to <u>10-1-60</u> and last saw her <sup>her</sup> alive on <u>10-1-60</u> Death occurred at <u>6:35</u> <u>PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Milton T. Engler M.D.</u>				22b. ADDRESS <u>Kirkville, Mo</u>				22c. DATE SIGNED <u>10-2-60</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-4-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lovell Cem</u>		23d. LOCATION (City, town, or county) <u>Milan, Mo</u>		(State)					
24. FUNERAL DIRECTOR <u>Dwight Schoen</u>				ADDRESS <u>Milan Mo</u>		25. DATE RECD. BY LOCAL REG. <u>10-6-1960</u>		26. REGISTRAR'S SIGNATURE <u>Mary W. Rathoff</u>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 8 1980

MILTON T. ENGLISH, M.D.

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 Dwight Schaefer

Licensed Embalmer No. 2667

P. O. Address Milan - Ill

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