URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-035472

STATE FILE NUMBER

FILED VS OCT 3 1960

NDED

Registration District No. 200 Primary Registration District No. _____ Registrar's No. 152

1. PLACE OF DEATH
a. COUNTY MACON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ~~ATLANT~~ A Lydia Twp
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION
Inside Limits Yes ☐ No ☑

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY MACON
c. CITY OR TOWN ATLANTA
Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location)
Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First Joseph Middle — Last Shears
4. DATE OF DEATH Month 9 Day 19 Year 1960
5. SEX Male
6. COLOR OR RACE White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 5/15/1883
9. AGE (last birthday) 77
IF UNDER 1 YEAR Months 4 Days 4
IF UNDER 24 HR Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Macon Co. Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A
13a. FATHER'S NAME Joseph Shears
13b. MOTHER'S MAIDEN NAME Mary Sheehan
14. NAME OF HUSBAND OR WIFE Nellie Shears
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. 487-18-8149
17. INFORMANT Nellie Shears Address – Atlanta, Mo

MEDICAL CERTIFICATION

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 Embolism — INTERVAL BETWEEN ONSET AND DEATH 30 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart
DUE TO (c) generalized Arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Hypertension
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Sept 9 1960, to Sept 9 1960 and last saw her/him alive on Death
Death occurred at 4:15 p m on the date stated above, and to the best of my knowledge, from the causes stated.

BY AFFIDAVIT OF

22a. SIGNATURE O. L. Woodward (Degree or title) DO
22b. ADDRESS Atlanta Mo
22c. DATE SIGNED 9-22-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 9-21-1960
23c. NAME OF CEMETERY OR CREMATORY Mt Tabor
23d. LOCATION (City, town, or county) (State) Atlanta – Mo.
24. FUNERAL DIRECTOR Theo H. Goodding ADDRESS – Atlanta Mo
25. DATE RECD. BY LOCAL REG. 9/25/60
26. REGISTRAR'S SIGNATURE Ruth McCreely

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

DEC 23 1960

OCT 3 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 Theo H. Goodling

Licensed Embalmer No. 3982

P. O. Address Atlanta,

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