

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004584

AMENDED

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 97

STATE FILE NUMBER

FILED VS FEB 20 1961

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wright</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>38 days</u>	c. CITY OR TOWN <u>Mansfield</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RT 2</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Dessie</u> Middle <u>MAE</u> Last <u>Shimel</u>			4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1961</u>			
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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>5-27-24</u>	9. AGE (last birthday) <u>36</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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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>DETROIT, Mich.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Willard Hoster</u>	13b. MOTHER'S MAIDEN NAME <u>Ada Bell Stewart</u>	14. NAME OF HUSBAND OR WIFE <u>Willard Shimel</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No

7. INFORMANT Address
Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio-Pulmonary failure

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hodgkins disease - Disseminated

DUE TO (c) _____

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)
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20c. TIME OF INJURY Hour _____ s.m. _____ p.m. _____	Month, Day, Year _____
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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 <u>Mansfield</u>	COUNTY <u>Wright</u>	STATE <u>Mo.</u>
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21. I attended the deceased from 1-6-61 to 2-10-61 and last saw her/him alive on 2-10-61
Death occurred at 9:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Morris Gordon M.D.</u>	22b. ADDRESS <u>Univ. Hosp Columbia Mo</u>	22c. DATE SIGNED <u>2-10-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>Feb. 10, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MANsfield</u>	23d. LOCATION (City, town, or county) (State) <u>MANsfield Mo.</u>
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24. FUNERAL DIRECTOR <u>Max & Miller</u>	ADDRESS <u>Mansfield Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Feb 11, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 21 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Max L Miller

Licensed Embalmer No. 4720

P. O. Address

Manoquid M

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.