

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH

Registration District No. **FILED IN 13102**

Primary Registration District No. **1003**

Registrar's No. **6569**

62-025187

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

ST-25346 XC-21 603 752

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Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY Morgan | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | Length of stay in 1b 24 DAYS | c. CITY OR TOWN JACKSONVILL Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, 915 N. GRAND AVE. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 215 N. Webster Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last DONALD C. SHOOK | | | 4. DATE OF DEATH Month Day Year 7/2/62 |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 1/28/17 |
| 9. AGE (last birthday) 45 | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor | | 10b. KIND OF BUSINESS OR INDUSTRY Heating Co. | 11. BIRTHPLACE (City and state or country) PEORIA, ILLINOIS |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME CLARENCE E. SHOOK | |
| 13b. MOTHER'S MAIDEN NAME LOLA E. SMITH | | 14. NAME OF HUSBAND OR WIFE GLADYS L. SHOOK | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWII | | 16. SOCIAL SECURITY NO. Not Available | 17. INFORMANT GLADYS L. SHOOK (WIDOW) SEE #2 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPERATION PNEUMONIA | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) G. I. TRACT HEMORRHAGE FROM THROMBOCYTOPENIA | | | |
| DUE TO (c) MYELOPROLIFERATIVE DISORDER | | | 296x |
| 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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.) | |
| 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 6/8/62 to 7/2/62 and last saw him alive on 7/2/62 Death occurred at 11:00 AM on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Gordon W. Phillips | | 22b. ADDRESS M.D. VAH, ST. LOUIS, MO. | 22c. DATE SIGNED 7/2/62 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 7-5-62 | 23c. NAME OF CEMETERY OR CREMATORY Park View Cemetery | 23d. LOCATION (City, town, or county) (State) Peoria, Ill |
| 24. FUNERAL DIRECTOR Williamson Funeral Home | ADDRESS Jacksonville, Ill. | 25. DATE RECD. BY LOCAL REG. JUL 3 1962 | REGISTRAR'S SIGNATURE Lois Smith, 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 me,
or by Not Embalmed, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John Hassly III

Licensed Embalmer No. 5039

P. O. Address E. St. Louis

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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.