

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-000188
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 27 Primary Registration District No. 5080 Registrar's No. 87

FILED JAN 15 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Bates</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Bates</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Deer Creek Twp.</u>		Length of stay in 1b <u>89 Years</u>	c. CITY OR TOWN <u>Deer Creek Twp.</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Deer Creek Twp.</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Martin Showalter</u>			4. DATE OF DEATH Month Day Year <u>January 7 1963</u>
5. SEX <u>Male</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>12-8-73</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Bates County, Mo.</u>
13a. FATHER'S NAME <u>Aaron Showalter</u>		13b. MOTHER'S MAIDEN NAME <u>Hannah Mull</u>	14. NAME OF HUSBAND OR WIFE <u>Susanne E. Showalter</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>NY</u>	17. INFORMANT Address <u>R.H. King, Adrian, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause of death) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia -</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Interstitial Nephritis 5yr</u> DUE TO (c) <u>Carcinoma Prostate</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>3 yr.</u>
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 type="checkbox"/> NO <input checked="" 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. Month, Day, Year p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>May 1957</u> to <u>Jan 7, 1963</u> and last saw him alive on <u>Jan 7, 1963</u> . Death occurred at <u>2:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or title) <u>Carter H. Butler M.D.</u>		22b. ADDRESS <u>Butler Mo</u>	22c. DATE SIGNED <u>1/8/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-9-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crescent Hill Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Adrian, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Six Funeral Service, Adrian, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-8-63</u>	26. REGISTRAR'S SIGNATURE <u>Norman Jean Wilson</u>

USE BLACK INK OR TYPEWRITER RIBBON

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 _____ *Claude P. Liff* _____

Licensed Embalmer No. 3650

P. O. Address Adrian, Mo.

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.