

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-005036

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 62

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 25 1963

VS 300
Rev. 4/59

1 0017

2 0017

3 2

4 0

5 1

6

7 0

8 2

9 331X

10

11

12 1-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

Germ

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u> Length of stay in lb <u>years</u>		c. CITY OR TOWN <u>Kirksville</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</u>		d. STREET ADDRESS (if outside, give location) <u>1401 West Hickory</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LESLIE THOMAS SHUBERT</u>			4. DATE OF DEATH Month <u>February</u> Day <u>16</u> Year <u>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>3/27/89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>linotype operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>newspaper</u>	9. AGE (last birthday) <u>73</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HR: Hours <u> </u> Min. <u> </u>
11a. BIRTHPLACE (City and state or country) <u>Kirksville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U S</u>	
13a. FATHER'S NAME <u>Elwood Shubert</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Naomi Boice</u>	
14. NAME OF HUSBAND OR WIFE <u>Effie Dye Clark Shubert</u>		17. INFORMANT Address <u>Effie Shubert, Kirksville, Mo.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of <u>No</u>)		16. SOCIAL SECURITY NO. <u>3</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</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 (e)			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. _____ 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>2-15-63</u> to <u>2-16-63</u> and last saw her alive on <u>2-16-63</u> Death occurred at <u>11:55</u> A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Edward M. Grim - M.D.</u>		22b. ADDRESS <u>Kirksv. Mo.</u>	22c. DATE SIGNED <u>2-18-63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 18/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Hills</u>	23d. LOCATION (City, town, or county) <u>Kirksville, Adair, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Foster Memorial Home, Kirksville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Feb 19, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Doris W. Gatliff</u>

MAR 18 1963

EDWARD M. GRIFFIN, M.D.

No permit issued

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 Novo E. Foster

Licensed Embalmer No. 4742
P. O. Address Kennelton 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.