

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-039401

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 93 Primary Registration District No. 4154 Registrar's No. 63-69
FILED NOV 5 1963 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Dade		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Dade	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Greenfield		Length of stay in 1b 5 yrs.	c. CITY OR TOWN Greenfield Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 509 College St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 509 College St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charles Middle Woodson Last Shouse			4. DATE OF DEATH Month Oct. Day 27 Year 1963
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 3-22-1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	9. AGE (last birthday) 91 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
13a. FATHER'S NAME John Caswell Shouse		13b. MOTHER'S MAIDEN NAME Campbell	12. CITIZEN OF WHAT COUNTRY U. S. A. 12. NAME OF HUSBAND OR WIFE Florence Alice Shouse
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Florence A. Shouse; Greenfield, Mo. Address 509 college st.
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia 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 (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			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input 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 <u>10-1-63</u> to <u>10-27-63</u> and last saw ^{him} alive on <u>10-27-63</u> Death occurred at <u>10:00</u> <u>P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) J. C. Canada M.D.		22b. ADDRESS Greenfield, Mo.	22c. DATE SIGNED 10-30-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 30, 1963	23c. NAME OF CEMETERY OR CREMATOR Greenfield Cem.	23d. LOCATION (City, town, or county) (State) Greenfield, Mo.
24. FUNERAL DIRECTOR J. C. Canada; Greenfield, Mo.		25. DATE RECD. BY LOCAL REG. Oct. 30, 1963	26. REGISTRAR'S SIGNATURE J. C. Canada

USE BLACK INK

OR

TYPEWRITER RIBBON

W.O. Cowan, M.D.

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Rev. 4/59

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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

J. C. Canada

Licensed Embalmer No. 4196

P. O. Address Treanfield, 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.