

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007568

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 55

FILED FEB 27 1963

VS 300  
Rev. 4/59  
1 0595  
2 05952  
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4 0  
5 1  
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7 0  
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9 331X  
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12 1-0  
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>LIVINGSTON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>LIVINGSTON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CHILLICOTHE</b>		Length of stay in 1b <b>26 YEARS</b>	c. CITY OR TOWN <b>CHILLICOTHE</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>CITY HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1503 CALHOUN ST.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>JANUARY</b> Last <b>SHY</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>22</b> Year <b>1963</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/30/1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ATTY. OF LAW</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LAW</b>	9. AGE (last birthday) <b>74</b> IF UNDER 1 YEAR: Months Days IF UNDER 24 HR: Hours Min.
11a. BIRTHPLACE (City and state or country) <b>BLACK, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>WILLIAM SHY</b>		13b. MOTHER'S MAIDEN NAME <b>PAULINE KENOWER</b>	14. NAME OF HUSBAND OR WIFE <b>MRS. J. J. SHY, SR.</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI &amp; WWII</b>		16. SOCIAL SECURITY NO. <b>497-46-4312</b>	17. INFORMANT <b>1503 Calhoun St. Chillicothe, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO (b) <b>Hypertensive vascular disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause (ast). 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 <b>7 hours</b> <b>unknown</b>	
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 _____ s.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 <b>July 1958</b> to <b>Feb 22, 1963</b> and last saw him alive on <b>Feb. 21, 1963</b> Death occurred at <b>1:00 A.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>William L. Fur, M.D.</b>		22b. ADDRESS <b>Chillicothe, Mo.</b>	
22c. DATE SIGNED <b>2/22/63</b> (State)		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
23b. DATE <b>2/24/63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>RESTHAVEN CEMETERY</b>	
23d. LOCATION (City, town, or county) <b>CHILLICOTHE, MISSOURI</b>		24. FUNERAL DIRECTOR <b>NORMAN FUNERAL HOME: Chillicothe, Mo.</b>	
25. DATE RECD. BY LOCAL REG. <b>Feb 23, 1963</b>		26. REGISTRAR'S SIGNATURE <b>Annalee Taylor</b>	

MAR 5 1963

**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 John P. Rodgers

Licensed Embalmer No. 4963

P. O. Address CHILLICOTHE, MISSOURI

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.

*Mr. W. D. Davis*