

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 36959

Registration District No. 725

Primary Registration District No. 4431

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County RALLS  
(b) City or town CENTER  
(c) Name of hospital or institution: \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community LIFE years, months or days

3. (a) PRINT FULL NAME ELIZABETH ANN SHULSE 420

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED  
6. (b) Name of husband or wife SHULSE 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased DEC 16 1857  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>8</u>	<u>12</u>	hr. _____ min.

9. Birthplace PIKE COUNTY MO  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business HOME

12. Name WILLIAM DEVIN

13. Birthplace MO

14. Maiden name ELIZABETH LEWELLEN

15. Birthplace RALLS CO MO  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ed Shulse

(b) Address CENTER MO

17. (a) BURIAL (b) Date thereof OCT 30  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CENTER

18. (a) Signature of funeral director COUCH AND HULSE

(b) Address CENTER MO

19. (a) 11/12/39 (b) Ed Shulse  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County RALLS

(c) City or town CENTER

(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 28  
year 1939 hour 9 minute 10 P. M.

21. I hereby certify that I attended the deceased from October 27, 1939, to October 28, 1939;

that I last saw her alive on Oct. 28, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration 2 days

Myocarditis - death

Due to unknown

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature P. H. Priddy (M. D. or other) do

Address Center, Mo. Date signed 11-12-39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

REV. 5-11-38 I X10511

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 10

District File Number 11-39-2007

Date Filed NOV 16 1939

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**