

2  
0.39  
-39  
21492

Registration District No. 700006

Primary Registration District No. 3038

Registrar's No. 144

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Marshall mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Pittsboro Hospital  
(If not a hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution seven hours  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME PATTY LOU Shisler

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced child

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased September 9 1940  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 8 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Sweet Springs Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Infant Child

11. Industry or business \_\_\_\_\_

12. Name Leo Schisler

13. Birthplace Benton County Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Louetta Khamel

15. Birthplace Saline County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Leo Schisler

(b) Address Sweet Springs Mo

17. (a) Burial (b) Date thereof Sept 18-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cemetery

18. (a) Signature of funeral director Jesse H. Arney

(b) Address Sweet Springs Mo

19. (a) 9-18-40 (b) D. Sp. J. Kent  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline  
(c) City or town Sweet Springs  
(If outside city or town limits, write "RURAL")  
(d) Street No. 100 Columbia Street  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17  
year 1940 hour 5:1 minute 10 P.M.

21. I hereby certify that I attended the deceased from Sept 11, 1940 to Sept 19, 1940  
that I last saw him alive on Sept 17, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death acute leukemia (atalectasis)

Due to Premature infant - 6 months

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

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

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature Doc Powers (M. D. or other) MD  
Address Sweet Springs Mo Date signed 9-18-40

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

10-18-40  
District File Number  
District Health Officer No. 8  
RECEIVED

**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.