

S. No. 2  
-11-10-39  
-5-17-39  
-1 X21429

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

14104  
State File No. \_\_\_\_\_  
Registrar's No. 90

FILED MAY 13 1944  
Registration District No. 2814

Primary Registration District No. 3006-5-1-20

10  
2  
4  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County BOONE COLUMBIA  
(b) City or town (If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: BOONE COUNTY HOSPITAL (If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 WEEKS (Specify whether years, months or days) 3 WEEKS

3. (a) PRINT FULL NAME MRS OLLIE SHINSTOCK  
8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race W  
6. (a) Single, widowed, married, divorced  
6. (b) Name of husband or wife GEO. SHINSTOCK  
6. (c) Age of husband or wife if alive 64 years  
7. Birth date of deceased MAY 28 1884 (Month) (Day) (Year)

8. AGE: Years 61 Months 10 Days 5 If less than one day hr. min.

9. Birthplace (State or foreign country)

10. Usual occupation HOUSE WORK

11. Industry or business  
MOTHER FATHER { 12. Name JAMES ROBIN GUE  
13. Birthplace SPAIN 5 (City, town, or county) (State or foreign country)  
MOTHER { 14. Maiden name NOT KNOWN  
15. Birthplace FRANCE 5 (City, town, or county) (State or foreign country)

16. (a) Informant MRS. RUTH COMPTON  
(b) Address MONTGOMERY CITY MO

17. (a) Burial (b) Date thereof 4-5-44 (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation ST. CHARLES MO

18. (a) Signature of funeral director E. Keilly  
(b) Address Italian Mo

19. (a) 4-4-1944 (b) Edna H. Barber (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County MONTGOMERY  
(c) City or town MONTGOMERY CITY MO (If outside city or town limits, write "RURAL")  
(d) Street No. 70 (If rural, give location)  
(e) If foreign born, how long in U. S. A. 1 years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 3 year 1944 hour 2 minute P.M.  
21. I hereby certify that I attended the deceased from 19 to 4-3-44 that I last saw him alive on 4-2-44 and that death occurred on the date and hour stated above.

Immediate cause of death: Recurrent Carcinoma Breast with metastases  
Duration 4 yrs.  
Due to 50  
Other conditions: (Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: Operation July 4, 1943  
Of operations Carcinoma  
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?  
While at work (Specify type of injury) (e) Means of injury  
23. Signature of physician (M. D. or other) O. H. S.  
Address Columbia Mo Date signed 4/3/44

1200

(Licensed Embalmer's Statement on Reverse Side)

OCT 25 1944

RECEIVED  
District Health Officer No. 9,  
District File Number.....  
Date Filed 5-11-44

MAY 17 1944

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 E. Keithly  
Licensed Embalmer No. 872  
P. O. Address Dallan 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 this body is not embalmed, above space should be left blank.