

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **21363**

Registration District No. **67**

Primary Registration District No. **6260**

Registrar's No. **6K**

1. PLACE OF DEATH:

(a) County **Christian**
 (b) City or town **Chadwick, Mo.**
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location) **1**
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community **About 50 years** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Christian**
 (c) City or town **Chadwick Mo 22**
 (If outside city or town limits, write "RURAL") **0**
 (d) Street No. _____ (If rural, give location) **0**
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____ **0**

3. (a) PRINT FULL NAME **John Shipman**

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

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **Rachel Shipman**
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **June 30 1860**
 (Month) (Day) (Year)

8. AGE: Years **83** Months **9** Days **20**
 If less than one day _____ hr. _____ min.

9. Birthplace **Christian Co., Missouri**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER { 12. Name _____
 13. Birthplace _____ (City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant **Reuben Shipman, (son)**

(b) Address **Chadwick, Mo**

17. (a) **Burial** (b) Date thereof **6-22-44**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Chadwick Cemetery**

18. (a) Signature of funeral director **John Harris**

(b) Address **Chadwick, Mo**

19. (a) **7-3-1944** (b) **Mrs. M. Johnson**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **21**
 year **1944** hour **6:00** minute _____ A.M.

21. I hereby certify that I attended the deceased from **June 19 1944** to **June 21 1944**
 that I last saw him alive on **June 19 1944**
 and that death occurred on the date and hour stated above.

Immediate cause of death **gangrene of both feet & leg** **17 days**
 Duration

Due to **chronic neglected Diabetes** **diabetes**

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: **61**
 Of operations _____
 Of autopsy _____

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) _____
 Means of injury _____

23. Signature **R. A. Farthing** M. D. or other _____

Address **Chadwick Mo** Date signed **6-29**

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 conform the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2B
-43
X38930

State File No. July
Registrar's No. 674

Registration District No. 67

Primary Registration District No. 5260

1. PLACE OF DEATH:

(a) County Christian
(b) City or town Chadwick Miss Chadwick
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 50 yr (Specify whether years, months or days)

3. (a) PRINT FULL NAME John Shipman

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased June 20 1915
(Month) (Day) (Year)

8. AGE: Years 82 Months 9 Days 25 All less than one day _____ min.

9. Birthplace Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Joe Shipman
13. Birthplace _____
14. Maiden name Polly Barnett
15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Jane Shipman
(b) Address Chadwick, Mo. (Niece)
17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January 21
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

REPRODUCING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY 21

21363