

No. 2  
2-43  
5-17-39  
X35897

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED FEB 26 1945.**

STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **6907**  
Registrar's No. **13**

Registration District No. **290** Primary Registration District No. **4481**

1. PLACE OF DEATH:  
(a) County **Pulaski**  
(b) City or town **Dixon**  
(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 \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Pulaski**  
(c) City or town **Dixon**  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME **John Bertley Shultz**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **2** day **13**  
year **1945** hour **5** minute **44 A.M.**

4. Sex **Male** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Minnie Shultz**  
6. (c) Age of husband or wife if alive **unknown** years  
7. Birth date of deceased **9 3 1864**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **January 4**, 19**45**, to **Feb. 9**, 19**45**;  
that I last saw him alive on **Feb. 9**, 19**45**,  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
**80 5 10** hr. min.

Immediate cause of death **Pneumonia**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Other conditions **Hernia strangulated**  
(Include pregnancy within 3 months of death)  
**Non-union fracture hip**  
Major findings:  
Of operations **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

10. Usual occupation **Retired Farmer**

11. Industry or business \_\_\_\_\_  
12. Name **Francis Shultz**  
13. Birthplace **Indiana**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Anna Ford**  
15. Birthplace **Indiana**  
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Mrs. John Shultz**  
(b) Address **Dixon, Missouri**  
17. (a) **Burial** (b) Date thereof **2/14/1945**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Pisgah**  
18. (a) Signature of funeral director **Fred H. Gilbert**  
(b) Address **Dixon, Missouri**  
19. (a) **2-16-1945** (b) **LeRoy M. Dodd**  
(Date received local registrar) (Registrar's signature)

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 **Dr. K. W. Milligan** (M. D. or other) \_\_\_\_\_  
Address **Dixon** Date signed **2/14/45**

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

1170

**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.....

.....  
working under my personal supervision.

*2/13-45*

..... Registered Apprentice No. ....

Signed.....  
*Fred W. Green*

..... Licensed Embalmer No. 2341.....

..... P. O. Address Dixon, 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 this body is not embalmed, fact should be so stated above.**

Registration District No. 290

Primary Registration District No. 4431

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Pulaski  
 (b) City or town Dixon  
(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 \_\_\_\_\_  
(Specify whether)  
 In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME

John B. Shultz

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 m

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

7. Birth date of deceased Sept 3  
(Month) (Day) (Year)

8. AGE: Years 80 Months 5 Days \_\_\_\_\_  
If less than one day

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

10. Usual occupation \_\_\_\_\_

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

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 \_\_\_\_\_

(b) Address \_\_\_\_\_

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 Feb day 3  
 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 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 \_\_\_\_\_

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

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

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

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

Major findings: Of operations No operation

Of autopsy No 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) Falling B. slip Accident

(b) Date of occurrence Approximately December 28<sup>th</sup> 1944

(c) Where did injury occur? Dixie, Pulaski, Mo. (Rural)  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
None home, on farm

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

23. Signature D. K. W. Mellisaw (or other) \_\_\_\_\_

Address Dixie, Mo. Date signed 3/28/45

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

SUPPLEMENTARY

69107