

3. No. 2  
1-8-43  
5-17-39  
P 1 X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **14183**

**FILED MAY 11 1945**

Registration District No. **277**

Primary Registration District No. **5911**

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

8000  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: *Remiscot*

(a) County *Pasco*, T.W.P.  
(b) City or town *Pasco*  
(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) *1*

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community *2 yrs* years, months or days

2. USUAL RESIDENCE OF DECEASED: *Remiscot*

(a) State *Missouri* (b) County *Remiscot*  
(c) City or town *Rural* *78*  
(If outside city or town limits, write "RURAL") *00*  
(d) Street No. *Pasco* *T.W.P.*  
(If rural, give location)

(e) Citizen of foreign country? *1* (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME *Clifton Bishop*

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Apr* day *7*  
year *1945* hour *2* minute *P.* M.

4. Sex *Male* 5. Color or race *Cal*

6. (a) Single, widowed, married, divorced *Married*

6. (b) Name of husband or wife *Alma Bishop* 6. (c) Age of husband or wife if alive *40* years

7. Birth date of deceased *22 1905*  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *on*  
*4-7-* 19*45* to \_\_\_\_\_ 19\_\_\_\_\_  
that I last saw him alive on *4-7-* 19*45*  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

*39 6 15* hr. min.

Immediate cause of death *Intentional*  
*Shots under toxicity dose*

Due to *Acute*

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

Due to *Fractured appendix*

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

10. Usual occupation *Farming*

11. Industry or business *Clifton Farm*

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

MOTHER FATHER

12. Name *Joe Bishop*

13. Birthplace *Batesville* *Miss*  
(City, town, or county) (State or foreign country)

Of autopsy *1211*

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

14. Maiden name *Wren Miller*

15. Birthplace *Batesville* *Miss*  
(City, town, or county) (State or foreign country)

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

16. (a) Informant *Theo Bishop*

(b) Address *Memphis Tenn*

17. (a) *Removal* (b) Date thereof *4-9-45*  
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? \_\_\_\_\_

(c) Place: burial or cremation *Memphis Tenn*

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury *2*

18. (a) Signature of funeral director *J. L. Master*

(b) Address *Wayne Mo*

19. (a) *5-3-45* (b) *Mrs. G. R. Cole*  
(Date received local registrar) (Registrar's signature)

23. Signature *J. L. Master* (M. D. or other) \_\_\_\_\_  
Address *Wayne Mo* Date signed *4-8-45*

4-45-90

**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.....  
*J. M. Hill*

Licensed Embalmer No..... *2627*

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, fact should be so stated above.**