S. No. 2
M—9-4-41
v. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED NOV 1 1945

State File No. 33245

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1136

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital Mo 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1-mo 29 Day (Specify whether
In this community Life 1-mo 29 d. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan 11
(c) City or town St Joseph 1
(If outside city or town limits, write "RURAL")
(d) Street No. 3516 Penn 7
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Nellie E. Shane

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

4. Sex F 1 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Earl Shane 6. (c) Age of husband or wife if alive —7 years

7. Birth date of deceased Feb. (Month) 28 (Day) 1898 (Year)

8. AGE: Years 47 Months 7 Days 25 If less than one day hr. min.

9. Birthplace St Joseph (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name John Shupe
13. Birthplace Nashaway (City, town, or county) Iowa 1 (State or foreign country)

MOTHER
14. Maiden name Sadie Jacobs
15. Birthplace Oregon (City, town, or county) Mo 0 (State or foreign country)

16. (a) Informant Hospital Record
(b) Address St Joseph Mo

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 10/25/45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director Weston BeSole & Bowman
(b) Address 319 So 10th

19. (a) 10-24-45 (Date received local registrar) (b) [signature] (Registrar's signature)

1428

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 23 year 1945 hour 12 20 minute a M.

21. I hereby certify that I attended the deceased from Aug 24, 1945 to Oct 22, 1945 that I last saw her alive on 10-22, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Meningo Encephalitis Syphilitica	
Due to Syphilitis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 30	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature E E Salyer (M. D. or other)
Address St Joseph Date signed 10/23/45

(Licensed Embalmer's Statement on Reverse Side)

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 Harold I. Wade

Licensed Embalmer No. 4072

P. O. Address St. Joseph

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.