

S. No. 2
DM-2-43
v. 5-17-39
X135697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37254

State File No. _____

Registrar's No. 94-3

FILED DEC 12 1945
Registration District No. 128

Primary Registration District No. 2000

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

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Springfield Baptist Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Webster
(c) City or town Nianqua - Rurde
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 1
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ollie May Shook
(b) If veteran, name war None
(c) Social Security No. NONE

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 17
year 1945 hour 11 minute 45 a.m.

4. Sex Female 5. Color or race whr
6. (a) Single, widowed, married, divorced married
(b) Name of husband or wife William V. Shook
(c) Age of husband or wife if alive 72 years
7. Birth date of deceased May 4, 1877
(Month) (Day) (Year)

I hereby certify that I attended the deceased from Nov 10 1945 to Nov 17 1945
and that death occurred on the date and hour stated above.
ImmEDIATE cause of death: Pulmonary embolus
Duration _____

8. AGE: Years 68 Months 6 Days 13
If less than one day hr. _____ min. _____

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

9. Birthplace Webster Co. Mo
(City, town, or county) (State or foreign country)
10. Usual occupation House wife

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

11. Industry or business _____
12. Name Perry Chaggin
13. Birthplace Ark Tenn
(City, town, or county) (State or foreign country)
14. Maiden name Hudson Mc Mahan
15. Birthplace Webster Co. Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Will Shook
(b) Address Nianqua, Mo.
17. (a) Burial (b) Date thereof 11-19-45
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

18. (a) Signature of funeral director Marshall
(b) Address Marshall
19. (a) 11-19-45 (b) W. H. H. H. H.
(Date received local registrar) (Registrar's signature)

23. Signature W. H. H. H. H. (M. D. or other) MD
Address Springfield, Mo. Date signed 11-19-45

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 *Lee Loney*
Licensed Embalmer No. *3312*
P. O. Address *Marshfield*

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.