

FILED JAN 25 1946

Registration District No.

Primary Registration District No. 2000

Registrar's No. 92

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirksville, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Community Nursing Home #4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Hospital
In this community 1 yr 5 mo 27 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Sullivan
(c) City or town Green Castle
(If outside city or town limits, write "RURAL")
(d) Street No. 5
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME MARY CRESTENASHEPLER

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive — years
7. Birth date of deceased 3 (Month) 15 (Day) 1862 (Year)

8. AGE: Years 83 Months 9 Days 5 If less than one day hr. min.

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

10. Usual occupation Old housework

11. Industry or business

MOTHER FATHER { 12. Name John Shepler
13. Birthplace Chocton, Ohio (City, town, or county) (State or foreign country)
14. Maiden name Nancy Williams
15. Birthplace Chocton, Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Mr. Sam Adams

(b) Address Green Castle Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Green Castle cemetery

18. (a) Signature of funeral director Elmer E. Feut

(b) Address Green City, Mo

19. (a) 12-28-45 (Date received local registrar) (b) Walter Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20 year 1945 hour 12 minute 15 P.M.

21. I hereby certify that I attended the deceased from July 16 1945 to Dec. 20 1945 that I last saw her alive on Dec 20 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia Duration 2 days
Due to Ca. of Breast yrs. —

Due to —
Other conditions (Include pregnancy within 3 months of death) —

Major findings: Of operations —
Of autopsy Hypostatic pneumonia of breast with metastasis to lungs

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? (c) Means of injury —

23. Signature Geo. J. Harrison (M.D. or other) M.D.
Address Kirksville, Mo Date signed 12/20/45

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

100021

RECEIVED

District Health Officer No. 10

District File Number 1-46-55

Date Filed JAN 23 1946

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 Archie W. Wade.....

Licensed Embalmer No. 3037.....

P. O. Address Green City Mo.....

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.