S. No. 2
M—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 4 1946

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 9999

Registration District No. 179 Primary Registration District No. 5668 Registrar's No. 11

**1. PLACE OF DEATH:**

(a) County Lincoln
(b) City or town Rural Clark Tw.
(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 June 1, 1945
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Lincoln 57
(c) City or town Wright City Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. 2 0
(If rural, give location)
(e) Citizen of foreign country? No. 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Henry Clinton Shoults

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male D

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Sarah Shoults

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug (Month) 7 (Day) 1864 (Year)

8. AGE: Years 80 Months 7 Days 1 If less than one day hr. min.

9. Birthplace Saint Louis (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Rail-road section hand

11. Industry or business Rail-road

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country) 9

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Mrs. Betty Kjar
(b) Address Wright City, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/46 (Month) (Day) (Year)
(c) Place: burial or cremation Cuba, Missouri.

18. (a) Signature of funeral director Nieburg F. & U. Co.
(b) Address Wright City, Missouri.

19. (a) March 16-46 (Date received local registrar) (b) Mrs. Emma B. Ridde (Registrar's signature)

162

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 8th
year 1946 hour 3 minute 45 P.M.

21. I hereby certify that I attended the deceased from March 7, 1946 to March 8, 1946, that I last saw him alive on March 7, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Heart Failure

Due to Shock

Due to Fracture Surgical Head Femur

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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 John B. Killoran MD (M.D. or other)
Address Wright City, MO Date signed 3/8/46

(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~~ by.

J Robert Sidmon, Registered Apprentice No. 400.

working under my personal supervision.

Signed Julius J. Nieburg

Licensed Embalmer No. 3366

P. O. Address Wright City Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

S. No. 2B
25M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 179 Primary Registration District No. 5668 Registrar's No. 11

SUPPLEMENTARY

**1. PLACE OF DEATH:**

(a) County Lincoln

(b) City or town Rural
(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)

**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

**3. (a) PRINT FULL NAME** Henry C. Shoults

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 Wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug (Month) 7 (Day) 1864 (Year)

8. AGE: Years 80 Months 7 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Mar 8
year 1946 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Fracture Left Hip

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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) Accident

(b) Date of occurrence March 7, 1946

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Farm Home
(Specify type of place)

While at work? (e) Means of injury Fell on Floor

23. Signature John B. Killoran M.D. (M.D. or other)

Address Knight City, Mo Date signed 4/6/46

8925

9999