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MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

37076

State File No.

FILED DEC 4 1948
Registration District No. 7

Primary Registration District No. 3028

Registrar's No. 266

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
McCune-Brooks Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 1/2 days
In this community 20 years
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Avilla
(If outside city or town limits, write "RURAL")
(d) Street No. ---
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 20
year 1948 hour 1:15 minute P M.
21. I hereby certify that I attended the deceased from
Mar 2 1948 to Nov 20 1948
that I last saw her alive on Nov 20 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Poisoning acute Duration
Pheno-barbital 2 days

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

Major findings:
Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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) _____ (e) Means of injury _____

23. Signature George H. Wood (M. D. number) _____
Address Carthage Mo Date signed 11-21-48

3. (a) PRINT FULL NAME OPAL VIRGINIA SHULLENBARGER

3. (b) If veteran, name war none 3. (c) Social Security No. _____

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Harry Shullenbarger 6. (c) Age of husband or wife if alive ---- years

7. Birth date of deceased July 12 1905
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
43 4 8 hr. min.

9. Birthplace Stone County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation cafe partner

11. Industry or business Joe's Cafe, Avilla, Mo.

12. Name Thomas O. Stewart

13. Birthplace Jennings County Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Lottie Wilson

15. Birthplace Stone County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Earl Stewart

(b) Address Avilla, Mo.

17. (a) burial (b) Date thereof Nov 23, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marionville Cemetery

18. (a) Signature of funeral director Knell Mortuary

(b) Address Carthage, Mo.

19. (a) 11-22-48 (b) H. B. Clinton, M.D.
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

48-11-987

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH

MAR 25 1985

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 Frank W. Kneel

Licensed Embalmer No. 4446

P. O. Address Carthage

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.

Registration District No. 157 Primary Registration District No. 3028

1. PLACE OF DEATH:

(a) County Jasper
 (b) City or town Carthage
 (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

Opal V. Shullenbarger

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 wid
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 12 (Month) (Day) (Year)

8. AGE: Years 43 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 7 year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions. (Include pregnancy within 3 months of death) 16 B.B

Major findings: Of operations _____

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) Suicidal

(b) Date of occurrence Nov. 18, 1948

(c) Where did injury occur? home - Abilla Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? home

While at work? no (Specify type of place) (e) Means of injury Took 24 (1/2 gr) phenobarbital tablets

23. Signature George H. Wood (M. D. or other)

Address Carthage, Mo. Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

S-37076