

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41700

State File No. _____

Registrar's No. 132

BIRTH NO. _____ REG. DIST. NO. 200 PRIMARY REG. DIST. NO. 5725

1. PLACE OF DEATH a. COUNTY MACON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL HUDSON		c. LENGTH OF STAY (in this place) 26 DAYS	
d. FULL NAME OF HOSPITAL OR INSTITUTION STILL-HILDRETH SAN.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Joplin	
		d. STREET ADDRESS (If rural, give location) 413 So. Cox	
3. NAME OF DECEASED (Type or Print) a. (First) MILLARD b. (Middle) J. c. (Last) SHREVE			4. DATE OF DEATH (Month) (Day) (Year) NOV. 12 1949
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 7, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Unknown	9. AGE (In years last birthday) 47
		11. BIRTHPLACE (State or foreign country) Uniontown, Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Clement M. Shreve		13b. MOTHER'S MAIDEN NAME Mary E. Wilson	14. NAME OF HUSBAND OR WIFE Ila Shreve
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. 509-10-6051	17. INFORMANT'S SIGNATURE OR NAME Miss Billie Shreve, Kansas City,
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) INTESTINAL OBSTRUCTION	
		INTERVAL BETWEEN ONSET AND DEATH 5 DAYS	
		ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) PARALYTIC ILEUS	
		DUE TO (c) MANIC-DEPRESSIVE PSYCHOSIS 2 yr.	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 5701	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
19a. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from OCT. 16, 1949 , to NOV. 12, 1949 , that I last saw the deceased alive on NOV. 12, 1949 , and that death occurred at 8:25 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Andrew T. Still D.O.		23b. ADDRESS MACON MO.	
23c. DATE SIGNED 11-12-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11/13/49	
24c. NAME OF CEMETERY OR CREMATORY Forest Park		24d. LOCATION (City, town, or county) (State) Joplin Mo.	
DATE REC'D BY LOCAL REG. 12/9/49		REGISTRAR'S SIGNATURE Walter M. Neely	
25. FUNERAL DIRECTOR'S SIGNATURE Albert Skurmer		ADDRESS MACON MO	

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

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RECEIVED 12/13/49
MACON COUNTY HEALTH DEPARTMENT
County File No. 12/49/58
Date Filed 12/28/49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Robert E. King

Licensed Embalmer No. 75-1

P. O. Address Macon 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.