

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9338**
 BIRTH NO. **FILED APR 12 1954** REG. DIST. NO. **187** PRIMARY REG. DIST. NO. **5699** Registrar's No. **94**

1. PLACE OF DEATH a. COUNTY Livingston		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Livingston	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Avalon	c. LENGTH OF STAY (In this place) 7 years	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Avalon	-0590
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) Jay	b. (Middle) Steven	c. (Last) Shipley	4. DATE OF DEATH (Month) (Day) (Year) April 2, 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH November 22, 1878	9. AGE (In years last birthday) 75	10. UNDER 1 YEAR Months	11. UNDER 2 HRS. Hours	12. UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Linn County, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S.
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13a. FATHER'S NAME Jim Shipley	13b. MOTHER'S MAIDEN NAME Amanda Gates	14. NAME OF HUSBAND OR WIFE Mary Ellen Williams
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. J. S. Shipley; Avalon, Missouri
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Four Minutes
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Quinocular Fibrillation		4 yrs
	ANTECEDENT CAUSES As for the conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardiac Decompensation DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **June 1, 1953**, to **Apr. 2, 1954**, that I last saw the deceased alive on **Mar. 27, 1954**, and that death occurred at **5:30 A. M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph A. Conrad M.D.	23b. ADDRESS Chillicothe, Mo	23c. DATE SIGNED Apr. 2-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-4-54	24c. NAME OF CEMETERY OR CREMATORY Avalon	24d. LOCATION (City, town, or county) (State) Avalon, Missouri
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DATE REC'D BY LOCAL REG. 4-2-54	REGISTRAR'S SIGNATURE Frances B. Neill	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Norman Funeral Home; Chillicothe, Mo.
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APR 10 1954

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 Elton Roman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, Missouri.

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.