No. 300
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WHITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED NOV 19 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37221

BIRTH NO. _____ REG. DIST. NO. 140 PRIMARY REG. DIST. NO. 5547 Registrar's No. 88

1. PLACE OF DEATH
a. COUNTY: Howard
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Monitean
c. LENGTH OF STAY (in this place): 55-yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural · Monitean Twsp
d. STREET ADDRESS (If rural, give location): 450

3. NAME OF DECEASED (Type or Print)
a. (First): SUSAN
b. (Middle): MARGARETT
c. (Last): SHIPE

4. DATE OF DEATH (Month) (Day) (Year): Oct. 30-54.

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single.
8. DATE OF BIRTH: Sept. 10, 1899
9. AGE (In years last birthday): 55. IF UNDER 1 YEAR: Months | Days IF UNDER 24 HRS.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home.
10b. KIND OF BUSINESS OR INDUSTRY: Home.
11. BIRTHPLACE (State or foreign country): Howard Co. Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: Wm. L. Shipe
13b. MOTHER'S MAIDEN NAME: Betty Shipe Nee.
14. NAME OF HUSBAND OR WIFE: Single
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no.
16. SOCIAL SECURITY NO.: none.
17. INFORMANT'S SIGNATURE OR NAME: Joe Shipe ADDRESS: Rocheport Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Chronic Myocarditis — 5 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Chronic Goitre (Toxic) — 5 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 30, 1954 to Oct 30, 1954, that I last saw the deceased ~~alive on~~ Dead 10-30, 1954, and that death occurred at 5:00 m., from the causes and on the date stated above.

23a. SIGNATURE: Wm Bloom (Degree or title) M.D. Coroner
23b. ADDRESS: Fayette Mo
23c. DATE SIGNED: 11-4-54.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 31-54
24c. NAME OF CEMETERY OR CREMATORY: Big Springs
24d. LOCATION (City, town, or county) (State): Monitean Twsp Mo

DATE REC'D BY LOCAL REG.: 11-4-54
REGISTRAR'S SIGNATURE: Mary K. Shell 436
B. FUNERAL DIRECTOR'S SIGNATURE: R. L. Hall ADDRESS:

(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 .....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed T. L. L. Stall

Licensed Embalmer No. 3515

P. O. Address New Franklin

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.