

FILED MAR 15 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5425

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>170</u>		PRIMARY REG. DIST. NO. <u>5635</u>		Registrar's No. <u>30</u>		
1. PLACE OF DEATH a. COUNTY <u>Laclede</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Phillipsburg-Laclede</u>		c. LENGTH OF STAY (in this place) <u>life</u>		c. CITY OR TOWN <u>Phillipsburg</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Phillipsburg, Mo.</u>				STREET ADDRESS (If rural, give location) <u>no street address</u> <u>0530</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u> b. (Middle) <u>Washington</u> c. (Last) <u>Bishop</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 1, 1955</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>Apr. 26, 1871</u>		
9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Minister</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Phillipsburg, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John L. Bishop</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Jane Rhinehart</u>			14. NAME OF HUSBAND OR WIFE <u>Pearl M. Bishop</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Det Meldrum Conway, Missouri</u>			
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) <u>Spinal Cord Paralysis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>thrombotic encephalomalacia</u> DUE TO (c) <u>Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hrs</u> <u>3 Days</u> <u>20-30 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>332 X</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 <u>Feb 18, 1955</u> to <u>Mar 1, 1955</u> , that I last saw the deceased alive on <u>Feb 27, 1955</u> , and that death occurred at <u>3:30p m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Frank G. De</u>				23b. ADDRESS <u>PO Box 13 Neigung Mo</u>		23c. DATE SIGNED <u>3-4-55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3/4/55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Lonesome Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Laclede County, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>3-4-1955</u>		REGISTRAR'S SIGNATURE <u>Hella L. Gray</u>		424 25. FUNERAL DIRECTOR'S SIGNATURE <u>Holman Funeral Home</u>		ADDRESS <u>Lebanon, Mo.</u>		

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

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APR 5 1965

Received ..... 3-14-55  
Laclede County Health Unit  
File No. .... 30  
Date Filed ..... 3-14-55

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.....  
Signature of Student Embalmer

Signed *Dorsey M. How*  
Licensed Embalmer No...4222

P. O. Address Lebanon, M1

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Facts to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.