No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 5 1955

State File No. 8910

BIRTH NO. _____ REG. DIST. NO. 233 ~~43-48~~ PRIMARY REG. DIST. NO. 5813 ~~2-3-3~~ Registrar's No. 7

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

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
c. LENGTH OF STAY (in this place): 1
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2 Miles South of Wellsville Mo

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

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): Adam
c. (Last): Shipler

4. DATE OF DEATH (Month) Mar (Day) 27 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): X 2
8. DATE OF BIRTH: Dec-8-1874
9. AGE (In years last birthday): 80
IF UNDER 1 YEAR: Months 3 Days 19
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Mo
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Allen Shipler
13b. MOTHER'S MAIDEN NAME: Anne Wiser
14. ~~NAME OF HUSBAND OR~~ WIFE: Dead

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: No
17. INFORMANT'S SIGNATURE OR NAME: Andrew S Shipler
ADDRESS: Wellsville

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): Cardiac Decompensation with Edema
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Bronchial Pneumonia
DUE TO (c): —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 3 days / 8 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 491 X
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* 3-15, 1955, *to* 3-27, 1955, *that I last saw the deceased alive on* 3-27, 1955, *and that death occurred at* 9:35 A. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): S. J. Beland, Mo
23b. ADDRESS: Wellsville Mo
23c. DATE SIGNED: 3-31-55

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 3-31-55
24c. NAME OF CEMETERY OR CREMATORY: [illegible]
24d. LOCATION (City, town, or county) (State): Wellsville Mo.

DATE REC'D BY LOCAL REG.: 3-31-55
REGISTRAR'S SIGNATURE: W.S. Romans Jr. 4-5-55
25. FUNERAL DIRECTOR'S SIGNATURE: Enlow, Russellville
ADDRESS: Mo

(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 .....

.....

working under my personal supervision.

Student Embalmer No. .....

Signed ..... A B Wells

Signed .....
Student Embalmer

Licensed Embalmer No. 1588

P. O. Address Wellsville M

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.