

Health,
Welfare
Public
Service

FILED FEB 25 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-004733
STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. _____ Registrar's No. 192

300
-57

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1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Bloomfield</u> <u>1039</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>S.E. Mo. Hosp.</u>		Length of stay in lb <u>1 week</u>	d. STREET ADDRESS (If outside, give location) <u>Route 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Curtis</u> Last <u>Shipman</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>13</u> Year <u>1958</u>		
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5, 1910</u>	9. AGE (In years last birthday) <u>47</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Concrete finisher</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>construction</u>	11. BIRTHPLACE (City and state or country) <u>Dexter, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Eligh M. Shipman</u>	13b. MOTHER'S MAIDEN NAME <u>Alice Vaughn</u>	14. NAME OF HUSBAND OR WIFE <u>Helen Shipman</u>
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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) <u>no</u> <u>X X X X X X X X X</u>	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Helen Shipman</u> Address <u>Bloomfield, Mo. R. 2</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanotic Carcinoma of lung</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Bronchogenic Carcinoma</u>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cardiac Arrest</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from Nov. 1957 to 1958 and last saw him alive on Feb. 13, 1958
Death occurred at 1:15 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Walter P. Kasten, M.D.</u>	(Degree or title)	22b. ADDRESS <u>937 Broadway Ave. Nevada</u>	22c. DATE SIGNED <u>2-18-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>2-15-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hill Cemetery</u>	23d. LOCATION (City, town, or county) <u>Dexter, Mo. Rural</u>	(State)
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24. FUNERAL DIRECTOR <u>Watkins & Sons</u>	ADDRESS <u>Dexter, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Feb. 21, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Homer E. Cooper</u>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

MAR 14 1958

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 *Marsh Watkins*

Licensed Embalmer No. *4717*

P. O. Address *Depton 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.