

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-029551  
STATE FILE NUMBER

FILED SEP 2 1958 Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 81

1. PLACE OF DEATH a. COUNTY <b>Missouri - Lawrence</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Christian</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mt. Vernon</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Sparta</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. State Sanatorium</b>		Length of stay in lb <b>28 days</b>	d. STREET ADDRESS (If outside, give location) <b>Route 1</b>
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Theodore</b> Middle <b>Shipman</b> Last <b>Shipman</b>			4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1958</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27, 1875</b>	9. AGE (In years and birthday) <b>83</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Hours <b>0</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (City and state or country) <b>Sparta, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Joseph Hiram Shipman</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Roberts</b>	14. NAME OF HUSBAND OR WIFE
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>San, records, Mo. State San., Mt. Vernon, Mo.</b>	Address
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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) <b>Right side cardiac failure</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>extensive bronchiectasis &amp; extensive vesicular emphysema</b>	<b>?</b>
	DUE TO (c) <b>526X</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? / YES <input checked="" type="checkbox"/> NO <input 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 <b>a.m.</b> Month, Day, Year	20d. INJURY OCCURRED WHILE AT <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 <b>Sparta</b>	COUNTY <b>Mo.</b>	STATE
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21. I attended the deceased from: <b>June 30, 1958</b> to <b>July 28, 1958</b> and last saw <del>her</del> <sup>him</sup> alive on <b>7-28-58</b> Death occurred at <b>1:30 a.m.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>C. Hellweg M.D.</b>	(Degree or title)	22b. ADDRESS <b>Mt. Vernon, Mo.</b>	22c. DATE SIGNED <b>7-28-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7-28-58</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or country) <b>Sparta</b>	(State) <b>Mo.</b>
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24. FUNERAL DIRECTOR <b>Max L. Fouquet</b>	ADDRESS <b>Mt. Vernon, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>8-12-58</b>	26. REGISTRAR'S SIGNATURE <b>Cecil Hendricks</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc.: most are only statistical in nature in item 18. NO symptoms will be stated. All diseases in Part I must be causally related.

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 *Max L. Foster* .....

Licensed Embalmer No. *4252* .....

P. O. Address *Wewona 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.