

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No.

14606

MAY 13 1940  
Registration District No. 171

Primary Registration District No. 5237

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Chariton  
(b) City or town Rural Fayetteville Twp.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether

In this community \_\_\_\_\_  
years, months or days) 11 8 3

3. (a) PRINT FULL NAME JOHN FRANKLIN SHULL

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Swiss Shull 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct. 2nd 1867  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
72 6 14 hr. \_\_\_\_\_ min.

9. Birthplace Fairfield Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business farming

MOTHER FATHER { 12. Name Andrew J. Shull

13. Birthplace Washington County Indiana  
(City, town, or county) (State or foreign country)

14. Maiden name Swiss

15. Birthplace Washington County Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. E. H. Babey

(b) Address Folden Mo

17. (a) Burial (b) Date thereof April 18-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funery

18. (a) Signature of funeral director H. G. Bennett

(b) Address Fayetteville Mo

19. (a) 4/19/40 (b) Mrs. Ray L. Babey  
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Chariton

(c) City or town 0 Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. 10 mile S.E. Fayetteville  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16th year 1940 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan 3, 1940, to month 8, 1940; that I last saw h. in alive on month 8, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Pneumonia Acute ?

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 11 W

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (a) Means of injury \_\_\_\_\_

23. Signature W. G. Babey (M. D. or other) \_\_\_\_\_

Address Georgetown Date signed 3/19/40

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED  
District Health Officer No. 8  
District File Number  
Date Filed 5/24/40

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed N. D. Barrett  
Licensed Embalmer No. 3046  
P. O. Address Key West, Fla.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**