

Registration District No. **12 1940** Primary Registration District No. **2001**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **SPRINGFIELD**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Springfield Baptist Hospital**
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Christian**
(c) City or town **Ozark**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **Twelfth** year **1940** hour **Twelve** minute **35** AM.
21. I hereby certify that I attended the deceased from **Oct 11 1940** to **Oct 12 1940**; that I last saw him alive on **Oct 11 (11pm)**, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death: **Basal skull fracture**
Traumatic scalp lacerations - hemorrhage
Due to _____

Duration **3 hours**
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN _____
Major findings: _____
Of operations _____
Of autopsy _____
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) **Accident**
(b) Date of occurrence **Oct 11 1940**
(c) Where did injury occur? **Greene County Mo**
(City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Public Highway**
While at work? _____ (Specify type of place) _____
(e) Means of injury **auto accident**
23. Signature **Daniel L Yancy** (M. D. or other) _____
Address **Springfield, Mo** Date signed **10-14-40**

3. (a) PRINT FULL NAME **Carl Shipman**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **394-18-3142**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive **XX** years

7. Birth date of deceased **don't know exact**
(Month) _____ (Day) _____ (Year) _____

8. AGE: Years **31 (about)** Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace **Sparta** **Missouri**
(City, town, or county) _____ (State or foreign country) _____

10. Usual occupation **laborer**

11. Industry or business _____

MOTHER FATHER { 12. Name **ISAAC Shipman**

13. Birthplace **Sparta** **Missouri**
(City, town, or county) _____ (State or foreign country) _____

14. Maiden name **Lydia Garrison**

15. Birthplace **Sparta** **Missouri**
(City, town, or county) _____ (State or foreign country) _____

16. (a) Informant **J. R. Hooper**

(b) Address **Springfield, Mo. R.R. #3**

17. (a) **Burial** (b) Date thereof **Oct. 13 1940**
(Burial, cremation, or removal) _____ (Month) (Day) (Year) _____

(c) Place: burial or cremation **OZARK CEMETERY**

18. (a) Signature of funeral director **T. B. Chaffin**

(b) Address **Ozark, Mo.**

19. (a) **Oct. 13 1940** (b) **W. E. Handley M.D.**
(Date received local registrar) _____ (Registrar's signature) _____

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

210 m
95

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.....

Myself

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Maurice Chaffin*

Licensed Embalmer No. *4118*

P. O. Address *Bank, 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 this body is not embalmed, above space should be left blank.

X

Registration District No. 318

Primary Registration District No. 2001

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Carl Shipman

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife, if alive 5 year _____

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

8. AGE: Years abt 31 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace: (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace: (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____

15. Birthplace: (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof: (Month) _____ (Day) _____ (Year) _____
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1/16/41 (b) W. E. Handley M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Basal Skull Fracture
Traumatic Scalp laceration - hemorrhage

Due to Auto accident - collision with other motor vehicle

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____

Of autopsy: 2107

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) acc

(b) Date of occurrence Oct 11 1940

(c) Where did injury occur: Green Co mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public
(Specify type of place)

While at work? 27th Street at Springfield

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

