

FEB 18 1941

Registration District No. 686

Primary Registration District No. 5914

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Like
 (b) City or town Curryville Rural
 (c) Name of hospital or institution 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution
 In this community 10 years
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Like
 (c) City or town Curryville Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 0
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME CHARLES FRANK SHUTT
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex Male **5. Color or race** White
6. (a) Status, widowed, married, divorced Married
6. (b) Name of husband or wife Juanne L. Shutt
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 23 1870
 (Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 10 If less than one day _____ by _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name Charles H. D. Shutt
13. Birthplace Ohio
 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Susan Metzger
15. Birthplace Ohio
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Juanne L. Shutt

(b) Address Curryville Mo
17. (a) Burial (b) Date thereof Jan 5 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Curryville Mo

18. (a) Signature of funeral director W. W. W. W.

(b) Address Van Dalias Mo
19. (a) Date received local registrar Jan 19 1941 **(b) Registrar's signature** Gene E. Hendrick

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 3
 year 1941 hour 5 minute _____ M.
21. I hereby certify that I attended the deceased from _____, 1940, to 12/12/40, 1940
 that I last saw him alive on 12/11, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Insufficiency
 Duration 1 yr

Due to _____
Due to _____
 Other conditions 95C
 (Include pregnancy within 3 months of death)

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? _____

23. Signature W. W. W. W. (Specify type of place) _____ (a) Means of injury _____
 While at work _____ (M. D. or other) _____

28. Signature W. W. W. W. **Date signed** 1/17/41
 Address Bowling Green

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state 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. 10

District File Number 2-41-347

Date Filed FEB 8 1941

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 W. B. Waters

Licensed Embalmer No. 3321

P. O. Address W. B. Waters

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.