

No. 2
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K21492

DEPARTMENT OF COMMERCE
BUREAU OF PUBLIC HEALTH
FILLED OCT 15 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31287

Registration District No. 135

Primary Registration District No. 3010

Registrar's No. 99

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Carrollton
(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
In this community _____
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Carroll
(c) City or town Carrollton
(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 J. O. Shinn
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 23
year 1941 hour 7 minute 15 P M.
21. I hereby certify that I attended the deceased from 7-19
1941 to 9-23, 1941;
that I last saw him alive on 9-23, 1941;
and that death occurred on the date and hour stated above.

4. Sex Mo 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Virginia Standley 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 23 1855
(Month) (Day) (Year)

Immediate cause of death Coronary Thrombosis Duration 2 min

8. AGE: Years 86 Months 1 Days 0 If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 942

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

10. Usual occupation Retired

11. Industry or business
12. Name Levi Shinn
13. Birthplace Mo
(City, town, or county) (State or foreign country)
14. Maiden name Rebecca Foster
15. Birthplace Mo
(City, town, or county) (State or foreign country)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Lyle Jones
(b) Address Farmers City Mo
17. (a) Burial (b) Date thereof 9-25-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oak Hill Home
18. (a) Signature of funeral director Standley
(b) Address Carrollton Mo
19. (a) 9-24-41 (b) W. H. Haskins
(Date received from registrar) (Registrar's signature)

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)
(e) Means of injury _____
23. Signature William B. Atwood (M. D. or other) _____
Address Carrollton Mo Date signed 9/24/41

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

RECEIVED
District Health Officer No. 8,
District File Number 10-14-41
Date Filed

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 Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton, Va

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31287

Registration District No. 135

Primary Registration District No. 3010

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrolleton
(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 _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME

J. O. Shinn

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 M

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug 23, 1855
(Month) (Day) (Year)

8. AGE: Years 86 Months 1 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Stanley

(b) Address _____

19. (a) 9-25-41 (b) Paul Haskin's
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 23
year 1941 hour _____ minute _____ M.

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

Duration _____

Due to _____
Due to _____

Other conditions _____
(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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

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

Address _____ Date signed _____

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

SUPPLEMENTARY

S-31287. 1941