

FILED FEB 13 1943

Registration District No. 47

Primary Registration District No. 3008

1. PLACE OF DEATH:

(a) County Callaway  
(b) City or town Fulton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital No 1 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 M 9 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Marion Shoop

3. (b) If veteran, name war ✓

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male Color of race White

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

6. (b) Name of husband or wife N/A

6. (c) Age of husband or wife if alive deceased years

7. Birth date of deceased (Month) (Day) (Year) about 1867

8. AGE: Years 70 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace N/A (City, town, or county) (State or foreign country) 9

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name N/A

13. Birthplace N/A (City, town, or county) (State or foreign country) 9

14. Maiden name N/A

15. Birthplace N/A (City, town, or county) (State or foreign country) 9

16. (a) Informant Record

(b) Address \_\_\_\_\_

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-43 (Month) (Day) (Year)

(c) Place: burial or cremation Stoungers Mt

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

(b) Address Callaway

19. (a) Jan 8-1943 (Date received local registrar) (b) Joan Morant Hoff (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Adair  
(c) City or town Kirkville  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 7 year 1943 hour 8-55 minute a M.

21. I hereby certify that I attended the deceased from 1-1-1943 to 1-7-1943

that I last saw him alive on 1-6-1943 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 2m +

Due to interosseal

Due to Blood Syphilis

Other conditions (Include pregnancy within 3 months of death) 309

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 0

23. Signature George H. Reens (M. D. or other) MD

Address Fulton Mo Date signed 1/7/43

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

4  
1  
2

14  
5

**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.....

*E. E. Nipper*

Licensed Embalmer No.....

4260

P. O. Address.....

*Blaine, Mt*

**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, fact should be so stated above.**