S. No. 2
M—9-4-41
5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

5491

State File No.

FILED MAR 5 1943

Registration District No. 1349 Primary Registration District No. 1002 Registrar's No. 950

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town R C
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lakeside Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 das (Specify whether
In this community 5 Days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Jackson 48 3
(c) City or town R-Calhoun 0
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? Ame (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME SHIFFLET Hattie June

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

4. Sex Fe
5. Color or race Wh
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: 8 Years | Months — | Days — | If less than one day — hr. — min.

9. Birthplace Calhoun MO (City, town, or county) (State or foreign country)
10. Usual occupation Child
11. Industry or business
FATHER
12. Name Jim Shifflet
13. Birthplace Unknown 9 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Unknown 9
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Jim Shifflet
(b) Address Calhoun Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-24-43 (Month) (Day) (Year)
(c) Place: burial or cremation Calhoun Mo
18. (a) Signature of funeral director J. Housey
(b) Address Calhoun Mo
19. (a) 2/22/43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 22
year 1943 hour 4 minute 40 p M.
21. I hereby certify that I attended the deceased from 2-18, 1943, to 2-22, 1943
that I last saw her alive on 2-22, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Septic Peritonitis — Duration 6 or 7 days
Due to Rupture of Appendicitis
Due to
Other conditions 12 11
(Include pregnancy within 3 months of death)
Major findings:
Of operations No Operation
Of autopsy NONE

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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature L. J. Graham (M. D. or other) D.O.
Address 811 Chambers Bldg Date signed 2-22-43

(Licensed Embalmer's Statement on Reverse Side)

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.