

No. 2
5-42
17-39
X3287

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31173

State File No.

FILED OCT 6 1943

Registration District No. 10

Primary Registration District No. 6722 #107

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Rural - Rocky Fork Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Rural - Rocky Fork Township
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community 44 Years (Specify whether years, months or days)

3. (a) PRINT FULL NAME ALMA SHOCK

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased 6 - 12 - 1899
(Month) (Day) (Year)

8. AGE: Years 44 Months 3 Days 3 If less than one day .hr. min.

9. Birthplace Boone County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER { 12. Name James Samuels
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Leona Sapp
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Sapp
(b) Address Route 1, Hallsville, Mo.

17. (a) Burial (b) Date thereof 9-17-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grandview Cemetery

18. (a) Signature of funeral director Parker Funeral Service
(b) Address Columbia, Mo.

19. (a) Sept 22 1943 (b) Mrs Ralph Bryan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone
(c) City or town Rural - Rocky Fork Township
(If outside city or town limits, write "RURAL")
(d) Street No. Route 1, Hallsville, Mo.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 15
year 1943 hour 9:00 minute A. 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.....

Due to Self inflicted razor wounds of the throat

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

Major findings: Of operations.....
Of autopsy.....

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 Mrs. McDaniel 3 (M.D. or other)
Address Columbia, Mo. Date signed 9/16/43

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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. 4138
P. O. Address..... Columbia, 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, fact should be so stated above.

Registration District No. **40** Primary Registration District No. **5122** Registrar's No. **7**

1. PLACE OF DEATH:

(a) County **Boone**

(b) City or town **Rural Rocky Fork Twp**
(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)

3. (a) PRINT FULL NAME **Alma Shock**

3. (b) If veteran, name war **3**

3. (c) Social Security No.

4. Sex **F**

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 **12** years

7. Birth date of deceased **June 12**
(Month) (Day) (Year)

8. AGE: Years **44** Months **2** Days **mo.** (If less than one day)

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) (Burial, cremation, or removal) **(b) Date thereof** (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) **(b)** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Boone**

(c) City or town **Rural Rocky Fork Twp**
(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** Year **1943** Hour **11** Minute **15** M.

21. I hereby certify that I examined the deceased from **Sept 15** 19**43** **11** **15** **M.**
that I last saw him **live** on **Sept 15** 19**43** and that death occurred on the date and hour stated above.
Immediate cause of death

Due to **Self Inflicted Razor Wound of the throat (left side)**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **164d**
Of operations **(none)**

Of autopsy **(none)**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **Suicide**

(b) Date of occurrence **Sept 15 - 1943**

(c) Where did injury occur? **at farm home**
(City or town) (County) (State)

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

23. Signature **Wain Milam** (M. D. or other)

Address **Columbia Mo** **Date signed** **10/1/43**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

Phone 8688

31173

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