DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 18 1943

Registration District No. 292

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38033

Primary Registration District No. 4434

Registrar's No.

1. PLACE OF DEATH:

(a) County Ralls

(b) City or town Center (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) In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ralls

(c) City or town Center (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Myrtle M. Shulse

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Ben F. Shulse

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased September 17 1886 (Month) (Day) (Year)

8. AGE: Years 57 Months 0 Days 20 If less than one day hr. min.

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

10. Usual occupation ~~Housework~~ Housewife

11. Industry or business Own home

MOTHER FATHER

12. Name W S Azbill

13. Birthplace (City, town, or county) Ky (State or foreign country)

14. Maiden name Sarah Aldredge

15. Birthplace (City, town, or county) Ky (State or foreign country)

16. (a) Informant's own signature Mrs E. Shulse

(b) Address Center Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-43 (Month) (Day) (Year)

(c) Place: burial or cremation Shulse Cemetery

18. (a) Signature of funeral director Fuller Funeral Home

(b) Address Center Mo

19. (a) Oct. 8-1943 (Date received local registrar) Mrs. Earl Perkinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17

year 1943 hour 10 a.m. minute M.

21. I hereby certify that I attended the deceased from July 7, 1943 to Oct. 7, 1943 that I last saw her alive on Oct. 7, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of Liver	5 mo.
Due to unknown	
Due to unknown	
Other conditions none (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
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 C. H. Brooks (M. D. or other) MD

Address Center, Mo. Date signed Oct. 8, 1943

1135

(Licensed Embalmer's Statement on Reverse Side)

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

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 11-4-1943-826
Date Filed NOV 16 1943

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 Giles R. Hulse

Licensed Embalmer No. 3356

P. O. Address Center Tex.

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.

No. 2B
5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Llec.

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH:
(a) County Ralls
(b) City or town Center
(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)
In this community life

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 .....

3. (a) PRINT FULL NAME Myrtle M. Shulse

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

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife .....

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

7. Birth date of deceased Sept. 17 1888
(Month) (Day) (Year)

8. AGE: Years 57 | Months 0 | Days 29 | If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
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) Oct 8-1943 (Date received local registrar) (Mrs. Earl Parkinson (Registrar's signature)

MEDICAL CERTIFICATION

SUPPLEMENTARY

20. DATE OF DEATH: Month Oct. day ..... year 1943 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... , 19..... to ..... , 19..... ; that I last saw h..... alive on ..... , 19..... ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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? .....
(Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

38939