

**FILED FEB 27 1944**

Registration District No. **42**

Primary Registration District No. **3007**

Registrar's No. **10**

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

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Paplar Bluff  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Paplar Bluff Hosp. O  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Days (Specify whether years, months or days)

In this community 4 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Ripley **91**

(c) City or town Daniphan Rural **3**  
(If outside city or town limits, write "RURAL")

(d) Street No. Rt 2  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs Dora Belle Sharum

3. (b) If veteran, name war \_\_\_\_\_

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 26 year 1943 hour 1:45 am minute \_\_\_\_\_ M.

(21) I hereby certify that I attended the deceased from Dec 24 1943 to Dec 26 1943 and that I last saw him alive on Dec 26 1943 and that death occurred on the date and hour stated above.

4. Sex Fe. 5. Color or race w.

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

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased Feb 14 1943  
(Month) (Day) (Year)

Immediate cause of death Peritonitis

Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day

50 10 12 hr. \_\_\_\_\_ min.

Due to Ruptured gall bladder

Due to Gangrene

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Ruptured gall bladder

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

10. Usual occupation House wife

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

12. Name Eli Fan

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

14. Maiden name Bessie Webb

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

16. (a) Informant Husband

(b) Address Daniphan

17. (a) Burial (b) Date thereof 12-26-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sowells Cent.

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? \_\_\_\_\_

18. (a) Signature of funeral director Blacks mortuary

(b) Address Daniphan Mo.

19. (a) 1-12-44 (b) Belle Kinne  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature Wm. H. ... (M. D. or other)

Address ... Date signed \_\_\_\_\_

RECEIVED

District Health Office No. 2,

District File Number 144-183

Date Filed 1-25-44

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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.....

*Mat E. Embalmed*

....., 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.