

FILED MAY 10 1944

State File No. _____

Registration District No. 325

Primary Registration District No. 4478

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Schuylers
(b) City or town Lancaster
(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
In this community 93 years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Schuylers
(c) City or town Lancaster
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

MARATH PICKENS SHOBE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2
year 1944 hour 6:15 minute _____ P. M.
21. I hereby certify that I attended the deceased from Mar 15
1944 to April 2, 1944,
that I last saw her alive on Mar 15, 1944,
and that death occurred on the date and hour stated above.

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased Mar 25 1851
(Month) (Day) (Year)

Immediate cause of death Myocardial Infarction
Due to _____
Due to Old Age
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

8. AGE: Years 93 Months _____ Days 17 If less than one day _____ hr. _____ min.

9. Birthplace Schuylers (City, town, or county) (State or foreign country) 0

10. Usual occupation _____

11. Industry or business _____

12. Name Samuel Lockitt
13. Birthplace Schuylers (City, town, or county) (State or foreign country) 0
14. Maiden name Wanda Silstray
15. Birthplace Schuylers (City, town, or county) (State or foreign country) 0

16. (a) Informant Otto Parris
(b) Address Lancaster

17. (a) Burial (b) Date thereof Apr 4 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation W. O. K. Glenwood

18. (a) Signature of funeral director P. J. ...

(b) Address _____

19. (a) April 4, 44 (b) A. Justice
(Date received local registrar) (Registrar's signature)

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 2

23. Signature R. E. Vaughn (M. D. or other) D.O.
Address Lancaster, Mo Date signed April 3, 44

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

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 5-4-916

Date Filed MAY 9 1944

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. 370

P. O. Address Lament

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. 13

Registration District No. 325 Primary Registration District No. 4478

1. PLACE OF DEATH:

(a) County Schuyler
(b) City or town Lancaster
(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 _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Marath P. Shobe

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

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

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

7. Birth date of deceased May 25 1944
(Month) (Day) (Year)

8. AGE: Years 93 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation Housewife

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) A. D. Justice

(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____

that I last saw him/her alive on _____, 19____ and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

15921