

S. No. 2
M-8-43
5-17-39
I X37823

39068

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 186

FILED DEC 3 1944

Registration District No. 200

Primary Registration District No. 6225

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

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Rural Washington
(c) Name of hospital or institution: State Hospital #3
(d) Length of stay: 1 day
In this community 1 day

3. (a) PRINT FULL NAME BENJAMIN SHIPMAN

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Mar?

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

7. Birth date of deceased Not obtained

8. AGE: Years 84(?) Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace Unknown

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. (a) Informant Patent

(b) Address Carthage Mo

17. (a) Burial (b) Date thereof 11-17-44

(c) Place: burial or cremation Cremation

18. (a) Signature of funeral director Miller Mrs.

(b) Address 11-20-44 (c) Hazel B. Beach

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jasper 10
(c) City or town Carthage
(d) Street No. _____
(e) Citizen of foreign country? No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov, day 15 (15)
year 1944 hour 5 minute 35 A.M.

21. I hereby certify that I attended the deceased from 11/14 to 11/15
that I last saw him alive on 11/14 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia acute

Due to _____

Due to _____

Other conditions _____

Major findings: Of operations _____

Of autopsy _____

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

(c) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature R. G. Hale Address Nevada Mo

MOTHER FATHER

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

1371

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

Death Officer No. 71

11-44-1334
12-5-44

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 L. R. Lemman

Licensed Embalmer No. 2297

P. O. Address Miller 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.