

S. No. 2
1-9-4-41
7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

31194

State File No.

Registrar's No. 100

FILED OCT 2 1945
Registration District No. 275

Primary Registration District No. 3053

81
2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
(a) County Phelps
(b) City or town: Rolla
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wells McFarland Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 29 days
(Specify whether
In this community same
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County DeWitt 33
(c) City or town Tuttle
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME Tom Shirley
3. (b) If veteran. name war. _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 9 year 1945 hour 1 minute 40 a M.

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced. W. V
6. (b) Name of husband or wife. _____ 6. (c) Age of husband or wife if alive. _____ years
7. Birth date of deceased. Sept 25 1871
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 11, 1945 to Sept 9, 1945
that I last saw him alive on Sept 9, 1945
and that death occurred on the date and hour stated above.
Immediate cause of death Prostateitis Duration _____

8. AGE: Years 73 Months 11 Days 16 If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions Prostatectomy performed
(Include pregnancy within 3 months of death) 8-14-45

9. Birthplace Tuttle Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation _____
11. Industry or business _____

Major findings:
Of operations _____
Of autopsy 1376
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
12. Name Dec Shirley
13. Birthplace Tuttle Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Sara Jane Wells
15. Birthplace Tuttle Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Eddie Eads
(b) Address Tuttle Mo.
17. (a) burial (b) Date thereof 9/11/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Stone Hill Cem
18. (a) Signature of funeral director Carl Spencer
(b) Address Salem Mo.
19. (a) Sept 13 1945 (b) Mr. Juanita Harvey
(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 Cl
23. Signature Phelps McFarland (M. D. or other) _____
Address Rolla Mo. Date signed 9/1/45

1403

(Licensed Embalmer's Statement on Reverse Side)

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..... *Carl H. Jensen*
Licensed Embalmer No..... *2370*
P. O. Address..... *Salem 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.