No. 2
I—2-43
5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED NOV 8 1945

State File No. 34901

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 155

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

1. PLACE OF DEATH:
(a) County Vernon
(b) City or town Rural Washington Tp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No 32
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr 6 mo 20 days (Specify whether)
In this community 1 yr 6 mo 20 days (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Greene 108
(c) City or town Rogersville Mo
(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 BESSIE GIVENS
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 Wid
6. (b) Name of husband or wife ✓
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased Oct (Month) 12 (Day) 1876 (Year)

8. AGE: Years 68 Months 11 Days 29 If less than one day hr. min.

9. Birthplace Bourbon Co (City, town, or county) Kan (State or foreign country)
10. Usual occupation None
11. Industry or business ✓
FATHER
12. Name Alfred B. Shipp
13. Birthplace Buffalo Ky (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Mary Jane Albert
15. Birthplace Buffalo Ky (City, town, or county) (State or foreign country)
16. (a) Informant Hospital record
(b) Address Nevada Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn
18. (a) Signature of funeral director Fred C. Thieme
(b) Address Springfield Mo.
19. (a) 10-15-45 (Date received local registrar) (b) Kathryn Yancey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 11 year 1945 hour 7 minute 30 p M.
21. I hereby certify that I attended the deceased from 2-22 1945 to 10-11 1945 that I last saw her alive on Oct 10 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Senile dementia	8
Due to	
Due to	
Other conditions: 2 rectal fistula (Include pregnancy within 3 months of death)	8

Major findings:
Of operations ✓
Of autopsy No

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 R G Hall M.D. (M.D. or other)
Address Nevada Mo Date signed 10/11/45

1499

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 10-45-1075
Date Filed 11-2-45

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 Fred C. Thieme

Licensed Embalmer No. 2899

P. O. Address Springfield, 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.