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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40995**

FILED JAN 5 1946

Registration District No. **80**

Primary Registration District No. **5307 4142**

Registrar's No. **11**

1. PLACE OF DEATH:

(a) County **Cole**
(b) City or town **Russellville, Mo.**
(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 **Life**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County **26**
(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 _____

3. (a) PRINT FULL NAME **Peter Shikles**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **888-444**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
(b) Name of husband or wife **Anna Shikles**
6. (c) Age of husband or wife if alive **81** years
7. Birth date of deceased **Dec. 23 1862**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec** day **19**
year **1945** hour **6** minute **0** M.

21. I hereby certify that I attended the deceased from **Nov. 1**, 1945, to **Dec 19**, 1945,
that I last saw him alive on **Dec 18**, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death, **Pernicious Anemia** 5 yrs
Duration

8. AGE: Years **82** Months **11** Days **26**
If less than one day _____ hr. _____ min.

9. Birthplace **Enon Rural** (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER { 12. Name **Peter Shikles, Sr.**
13. Birthplace **Ky.** (City, town, or county) (State or foreign country)
14. Maiden name **Louisa Hale**
15. Birthplace **High Point, Mo.** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Peter Shikles**

(b) Address **Russellville, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **12/21/45** (Month) (Day) (Year)

(c) Place: burial or cremation **Enloe Cem.**

18. (a) Signature of funeral director **H. H. Schubert**

(b) Address **Russellville, Mo.**

19. (a) **Dec. 21, 1945** (Date received local registrar) (b) **Mrs. Minnie Nuttermyer** (Registrar's signature)

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: **1730**
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 **0**

23. Signature **Walter S. Leslie** (M. D. or other)
Address **Russellville, Mo.** Date signed **2-20-46**

1439

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 1-3-46

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 N. H. Schubert

Licensed Embalmer No. 2820

P. O. Address Russellville, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 11

Registration District No. 80

Primary Registration District No. 4142

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Russellville
(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 Peter Shiples

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 M

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

7. Birth date of deceased Dec 23, 1862
(Month) (Day) (Year)

8. AGE: Years 82 Months 2 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Mrs. Minnie Hittmeyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole

(c) City or town Russellville
(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 _____ Day _____ Year _____ Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ 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

40995