

FILED APR 29 1946 STANDARD CERTIFICATE OF DEATH

13371

State File No.

Registrar's No.

Registration District No. 149

Primary Registration District No. 1002

1771

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Keokuk  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1723 Duquette  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community unknown years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town Keokuk  
(If outside city or town limits, write "RURAL")  
(d) Street No. 548 Main  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Wm J SHIMP

3. (b) If veteran, name war no 3. (c) Social Security No. 524-225462

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

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
app # 62 hr. min.

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

10. Usual occupation Laborer

11. Industry or business unknown

12. Name unknown

13. Birthplace unknown (City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Emma M Shimp

(b) Address R # 2 Hedgerville W. V.

17. (a) Removal (b) Date thereof 4-15-46 (Month) (Day) (Year)

(c) Place: burial or cremation W Leabroy Cem Keokuk

18. (a) Signature of funeral director Sebbeto's

(b) Address City  
19. (a) 4-15-46 (Date received local registrar) (b) S Geraldine Holman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 10th year 46 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, 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 Reputy Coroner Duration \_\_\_\_\_

Acute asphyxiation

Due to Fall into Grain Bin.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Includes pregnancy within 3 months of death)

Major findings: 182-2  
Of operations \_\_\_\_\_

Of autopsy See Above

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) Accident 123

(b) Date of occurrence 4/10/46

(c) Where did injury occur? Harvas City (City or town) (County) (State) Mo

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

While at work? Yes (Specify type of place) Asphyxia Means of injury

23. Signature A. E. Userer (M. D. or D. O.) M. D.  
Address 2800 Main Date signed 4/12/46

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

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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..... *Harry Chapman* .....

Licensed Embalmer No..... *2041* .....

P. O. Address..... *Kc. 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.**