

FILED SEP 10 1946

Registration District No. 99

Primary Registration District No. 4154

Registrar's No. 64

1. PLACE OF DEATH:

(a) County DADE
(b) City or town GREENFIELD
(If outside city or town limits, write "RURAL," and name of township)
(c) Name of hospital or institution:
GARRETT STREET
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No
(Specify whether
In this community 86 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County DADE 29
(c) City or town GREENFIELD 1
(If outside city or town limits, write "RURAL")
(d) Street No. GARRETT STREET 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

3. (a) PRINT FULL NAME CARRIE W. SHIPLES

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

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOW
6. (b) Name of husband or wife JAMES S. SHIPLES 6. (c) Age of husband or wife if alive 4 years
7. Birth date of deceased JANUARY 4 1850
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 29
year 1946 hour 11 minute P. M.

21. I hereby certify that I attended the deceased from Aug 22, 1946, to Aug 29, 1946, that I last saw h. ET alive on Aug 29, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death Acute Dilatation of heart
Due to Chronic Myocarditis

Duration

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 93!

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 2

23. Signature J. A. Sauer M.D. (M. D. or other) _____
Address Greenfield, Mo. Date signed 9/3/46

8. AGE: Years 96 Months 7 Days 25 If less than one day _____ hr. _____ min.
9. Birthplace _____ (City, town, or county) TEXAS (State or foreign country)
10. Usual occupation HOME
11. Industry or business HOME
12. Name No RECORD
13. Birthplace No RECORD (City, town, or county) (State or foreign country) 9
14. Maiden name No RECORD
15. Birthplace No RECORD (City, town, or county) (State or foreign country) CA
16. (a) Informant Ottis Headlee
(b) Address Greenfield, Mo.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-31-46 (Month) (Day) (Year)
(c) Place: burial or cremation GREENFIELD CEMETERY
18. (a) Signature of funeral director Sam S. Sweeney Jr.
(b) Address Greenfield, Mo.
19. (a) Sept 2-46 (Date received local registrar) (b) Lee S. Wray (Registrar's signature)

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

25545

35

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 Sam E. Senseney Jr
Licensed Embalmer No. 4099
P. O. Address Greenfield, 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.