

FILED SEP 18 1946

Registration District No. **155** Primary Registration District No. **3427** Registrar's No. **136**

1. PLACE OF DEATH:

(a) County **Jasper**
 (b) City or town **North City**
 (c) Name of hospital or institution: **Jones Memorial Hospital**
 (d) Length of stay: In hospital or institution **3 weeks**
 In this community **3 weeks**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper**
 (c) City or town **North City**
 (d) Street No. **732 N. Dougherty**
 (e) Citizen of foreign country? **NO**
 If yes, name country _____

3. (a) PRINT FULL NAME

Abbie Stout Shuey
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color of race **White**
 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **Widowed**
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Unknown**

8. AGE: Years **83** Months _____ Days _____ If less than one day _____ hy. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER {
 12. Name **Unknown**
 13. Birthplace _____
 14. Maiden name **Unknown**
 15. Birthplace _____

16. (a) Informant **Records**
 (b) Address **North City, Mo**

17. (a) **Burial** (b) Date thereof **7-14-1946**
 (c) Place: burial or cremation **Mount Hope Cem**

18. (a) Signature of funeral director **North City, Ind Co**
 (b) Address **North City, Mo**

19. (a) **SEPT-12-46** (b) **P.L. Shetler**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **8**
 year **1946** hour **8:30** minute **0** M.
 21. I hereby certify that I attended the deceased from **Aug 20**
1946 to **Sept 8** 19**46**
 that I last saw her alive on **Sept 8** 19**46**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Shock & in aortic aen**
a fractured hip
 Due to _____ Duration **3 weeks**

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: **SUPPLEMENTARY INFORMATION REQUESTED**
 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? _____
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place)
 Signature **P.H. Stymont** (M. D. or other) **0**
 Address **North City, Mo** Date signed **9/10/46**

137

468-791

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.....

Harvey E. Armer....., Registered Apprentice No. *412*
working under my personal supervision.

Signed..... *P. K. Mills*.....

Licensed Embalmer No. *347*

P. O. Address *Waco City, Tex.*

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. *Oct*

Registration District No. *155*

Primary Registration District No. *3127*

Registrar's No. *136*

1. PLACE OF DEATH:

(a) County *Jasper*
(b) City or town *Webb City*
(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 *Abbie S. Shuey*

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

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *wid*

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

7. Birth date of deceased (Month) *March* (Day) _____ (Year) _____

8. AGE: Years *83* Months _____ Days _____ (If less than one day) _____ hr. _____ min.

9. Birthplace (City, town, or county) *Mich* (State or foreign country) _____

10. Usual occupation _____

11. Industry or business _____

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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Aug* Year *1946* 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

(a) Accident, suicide, or homicide (specify) *accident*

(b) Date of occurrence *Aug 20 1946*

(c) Where did injury occur? *Webb City, Jasper Co* (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? *from a fall on the street* (Specify type of place) _____

23. Signature *R. M. Stover* (M. D. or other) _____

Address *Webb City Mo* Date signed *8/21/46*

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING INK

29580

30748