

Registration District No. **128**

Primary Registration District No. **5466**

Registrar's No. **960**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **RURAL S Campbell Twp**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
OSZARK OSTEOPATHIC HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7** (Specify whether
In this community **4 weeks**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **BARRY**
(c) City or town **RURAL - PURDY**
(If outside city or town limits, write "RURAL")
(d) Street No. **4 MI S.E. of Purdy**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MARTHA JANE SHIPMAN**

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 **M /**
6. (b) Name of husband or wife **James M. Shipman** 6. (c) Age of husband or wife if alive **78** years
7. Birth date of deceased **MARCH 1882**
(Month) (Day) (Year)

8. AGE: Years **64** Months **8** Days **24** If less than one day
-- hr. -- min.

9. Birthplace **Douglas Co. MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

12. Name **T. J. Prueitt**
13. Birthplace **Ind.**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary M. Mills**
15. Birthplace **Tenn!**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. James M. Shipman**
(b) Address **Rt #1, Purdy, Mo.**

17. (a) **Burial** (b) Date thereof **12-1-1946**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Day Cemetery**

18. (a) Signature of funeral director **W. C. Koon**
(b) Address **Cassville, Mo.**

19. (a) **12-13-46** (b) **W. C. Koon**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **29**
year **1946** hour **2:15** minute **A.M.**

21. I hereby certify that I attended the deceased from **10-28**
1946 to **Nov-29**, 19**46**
that I last saw her alive on **10-28**, 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Adeno carcinoma**

Due to _____

Due to **46H**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Adenocarcinoma infiltrating the omentum**
Of operations _____
Of autopsy _____

Duration

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)
(c) Manner of injury **3.0 ✓**

23. Signature **William J. Haggard**
Address **Springfield, Mo** Date signed **12/1/46**

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

39121

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 J. C. Canada
Licensed Embalmer No. 4196
P. O. Address Carroll, 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.