

S. No. 2  
 DM-5-43  
 v. 5-17-39  
 I X36671

DEPARTMENT OF HEALTH OF THE STATE BOARD OF HEALTH OF MISSOURI  
 BUREAU OF THE CENSUS  
**FILED MAY 5 1947**  
**STANDARD CERTIFICATE OF DEATH**

State File No. **16045**

Registration District No. **324** Primary Registration District No. **3072** Registrar's No. **78**

**1. PLACE OF DEATH:**  
 (a) County Saline  
 (b) City or town Marshall  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
473 So. Grant  
 (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 MO (b) County Saline 97  
 (c) City or town Miami "Rural" 0  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 11 mi. S.W. Miami MO 0  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No) 0  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** ERMAL RUTH SHULL  
 3. (b) If veteran, \_\_\_\_\_ 3. (c) Social Security \_\_\_\_\_  
 name war \_\_\_\_\_ No. \_\_\_\_\_  
 4. Sex Female 5. Color or race W  
 6. (a) Single, widowed, married, divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
 \_\_\_\_\_ alive \_\_\_\_\_ years  
 7. Birth date of deceased Feb. 22 - 1947  
 (Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month Apr day 12  
 year 1947 hour 3 minute 10 A.M.  
 21. I hereby certify that I attended the deceased from Apr 4  
 1947 to Apr 12 1947  
 that I last saw h. or alive on Apr 11 1947  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>1</u>	<u>20</u>	_____ hr. _____ min.

Immediate cause of death Pneumonia 7 days  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

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

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

**MOTHER**  
 10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_  
**FATHER**  
 12. Name Normal P. Shull  
 13. Birthplace Shackelford MO  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Milma J. Peel  
 15. Birthplace Slater MO  
 (City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Normal P. Shull  
 (b) Address Miami MO: R. 2.  
 17. (a) Burial (b) Date thereof 4-14-47  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
Summit Memorial Garden Marshall MO  
 (c) Place: burial or cremation  
 18. (a) Signature of funeral director Harry Heriberg  
 (b) Address Marshall MO  
 19. (a) April 14 - 1947 (b) Sedney T. Gray  
 (Date received local registrar) (Registrar's signature)

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 [Signature] (M. D. or other) \_\_\_\_\_  
 Address [Signature] Date signed 4/14/47

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

47  
 1  
 2

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 5-2-47

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.....

<sup>not</sup>

was not embalmed

Registered Apprentice No.....

working under my personal supervision.

Signed Harry Hershberger

Licensed Embalmer No. 4357

P. O. Address Marshall 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.