

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 19 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19972

Registration District No. 374

Primary Registration District No. 4548

Registrar's No. 42

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Worth
(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 2 1/2 years (Specify whether years, months or days)
In this community 2 1/2 years

3. (a) PRINT FULL NAME William Burton Shipley

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Zona Roberts Shipley 6. (c) Age of husband or wife if alive 12 years (Month) (Day) (Year)
7. Birth date of deceased August 12 1875 (Month) (Day) (Year)

8. AGE: Years 71 Months 8 Days 17 If less than one day hr. min.

9. Birthplace Worth Co Mo (City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business

12. Name Robert Newton Shipley
13. Birthplace Toledo Ohio (City, town, or county) (State or foreign country)
14. Maiden name Susan Brown Shipley
15. Birthplace Ottumwa Iowa (City, town, or county) (State or foreign country)

16. (a) Informant Annie Shipley
(b) Address Grant City, Mo.

17. (a) Burial (b) Date thereof May 2, 1947 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grant City Cemetery

18. (a) Signature of funeral director Arch C. Duffell

(b) Address Grant City, Mo.

19. (a) May 7 1947 (b) Lt. E. Dawson (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Worth
(c) City or town Worth (If outside city or town limits, write "RURAL")
(d) Street No. / (If rural, give location)
(e) Citizen of foreign country no (Yes or No)
If yes, name country /

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29 year 1947 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from / to / that I last saw him alive on / and that death occurred on the date and hour stated above.

Immediate cause of death: Compensatory aneurysm of aorta Duration 3 min
Due to /

Due to /
Other conditions (Include pregnancy within 3 months of death) /

Major findings: Of operations / Of autopsy / 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 / 23. Signature Arch C. Duffell (M. D. or other) Cor. Address Grant City Date signed 5-3-47

SEP 22 1948

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....

Arch C. Dingle

Licensed Embalmer No.

3252

P. O. Address.....

Grant City, 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.