

FILED SEP 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31218

State File No.

14 - PERMANENT RECORD 2

BIRTH NO. _____ REG. DIST. NO. 251 PRIMARY REG. DIST. NO. 3048 Registrar's No. 222

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Worth	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maryville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sheridan - rural	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hospital		d. STREET ADDRESS (If rural, give location) 2 1/2 miles northeast	
3. NAME OF DECEASED (Type or Print) a. (First) ELLWOOD b. (Middle) LEROY c. (Last) SHINABARGAR			4. DATE OF DEATH (Month) (Day) (Year) 9 16 49
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 7/6/99
9. AGE (In years last birthday) 50		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Wilcox, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Charles Shinabargar		13b. MOTHER'S MAIDEN NAME Maggie Dempsey	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Roena Pratt, Sheridan, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Edema ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Acute Cardiac Failure DUE TO (c) Bronchiectasis & Bronchial Asthma II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from _____, 19____, to Sept. 16 1949 , that I last saw the deceased alive on _____, 19____, and that death occurred at 3:10A m., from the causes and on the date stated above.			
23a. SIGNATURE Frank B. Matthews (Degree or title) M. D.		23b. ADDRESS Grant City, Mo.	
23c. DATE SIGNED 9-19-49		24a. BURIAL, CREMATION, REMOVAL (Specify) burial	
24b. DATE 9/19/49		24c. NAME OF CEMETERY OR CREMATORY Miriam	
24d. LOCATION (City, town, or county) (State) Maryville, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Price Funeral Home, Maryville, Mo.	
DATE REC'D BY LOCAL REG. 9-24-49		REGISTRAR'S SIGNATURE Bess Holt	

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



OCT 6 1949

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 _____

ROBERT L. SOUTER

Student Embalmer No. 309

working under my personal supervision

Student Robert L. Souter
Student Embalmer

Signed _____

Clayton M. Prew

Licensed Embalmer No. 1822

P. O. Address Maryville 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.