

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32908

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>8</u>		PRIMARY REG. DIST. NO. <u>5034</u>		Registrar's No. <u>11</u>	
1. PLACE OF DEATH a. COUNTY <u>Audrain</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>			
b. CITY OR TOWN <u>Rural - (Prairie)</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural (Prairie)</u>		d. STREET ADDRESS (If rural, give location) <u>4 mi. N. Rush Hill, Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4 mi. N. Rush Hill, Mo.</u>				d. STREET ADDRESS (If rural, give location) <u>4 mi. N. Rush Hill, Mo.</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Harry</u>		b. (Middle) <u>Walter</u>		c. (Last) <u>Shoup</u>	
4. DATE OF DEATH		(Month) <u>10</u>		(Day) <u>27</u>		(Year) <u>49</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Nov. 26, 1860</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>1</u>	IF UNDER 2 HRS. Hours <u>1</u> Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Shoup</u>		13b. MOTHER'S MAIDEN NAME <u>Barbara Markley</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Mattie Shoup</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mr. Clyde Shoup, Laddonia</u>			
15. ADDRESS _____		17. ADDRESS _____				17. ADDRESS _____	
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) <u>Senescence of age</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Cardiovascular disease</u>		DUE TO (c) <u>arteriosclerotic syndrome of foot</u>		1 yr	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						6 mo	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>Mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____		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 <u>5-18</u> , 19 <u>49</u> , to <u>10-28</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>9-6</u> , 19 <u>49</u> , and that death occurred at <u>4 1/2</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Disease or title) <u>W. Kallenbach M.D.</u>				23b. ADDRESS <u>Mexico Mo</u>		23c. DATE SIGNED <u>Oct 28, 49</u>	
24a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10/28/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Mexico, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>10-28-49</u>		REGISTRAR'S SIGNATURE <u>Martha Kennerly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hilbur Biedloff, Laddonia</u>			
				ADDRESS _____			

(Licensed Embalmer's Statement on Reverse Side)

710.

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

NOV 17 1949

RECEIVED NOV 2 1949
District Health Officer No. 10
District File Number 11-49-187
Date Filed NOV 2 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed John F. Ellis
Licensed Embalmer No. 4613
P. O. Address Perry, 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.