

FILED AUG 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23996**

BIRTH NO. _____ REG. DIST. NO. **195** PRIMARY REG. DIST. NO. **5718** Registrar's No. **43**

1. PLACE OF DEATH a. COUNTY McDonald		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY McDonald	
b. CITY (If outside corporate limits, write RURAL, and give township) Southwest City (Rural)		c. CITY (If outside corporate limits, write RURAL, and give township) Southwest City (Rural)	
c. LENGTH OF STAY (In this place) 2 1/2 yrs		d. STREET ADDRESS (If rural, give location) Rural	
d. FULL NAME OF HOSPITAL OR INSTITUTION None			

3. NAME OF DECEASED (Type or Print) a. (First) Walter b. (Middle) William c. (Last) Shell	4. DATE OF DEATH (Month) (Day) (Year) 7-3-50
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED! (Specify) Never Married	8. DATE OF BIRTH 1-13-1867	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months 5 Days 22	IF UNDER 24 HRS. Hours Min.
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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) INDIANA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Peter Shell	13b. MOTHER'S MAIDEN NAME Submitta Bredbecker	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Wm. D. Shell	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Sinuity		
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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **July 2**, 19**50**, to **July 5**, 19**50**, that I last saw the deceased alive on **7-2-50**, 19**50**, and that death occurred at **7 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE R. E. Warmack, M.D. (Degree or title)	23b. ADDRESS Southwest City, Mo.	23c. DATE SIGNED 8-3-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-7-50	24c. NAME OF CEMETERY OR CREMATORY Deatoga	24d. LOCATION (City, town, or county) (State) Southwest City, Mo.
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DATE REC'D BY LOCAL REG. 8-4-50	REGISTRAR'S SIGNATURE Mayme Humphrey	423	25. FEDERAL DIRECTOR'S SIGNATURE T. W. Humphrey	ADDRESS Kennett, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

6600

DIVISION OF HEALTH OF MO.

District No. 5 - Springfield

RECEIVED AUG 7 1950

Dist. File 850-944

Date Filed 8-7-50

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 A. M. Humphrey Jr.

Licensed Embalmer No. 4767

P. O. Address Noel, 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.