

FILED OCT 20 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 34715  
Registrar's No. 934

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>934</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (In this place) <u>30 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		<u>0396</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>423 1/2 South Campbell</u>				d. STREET ADDRESS (If rural, give location) <u>423 1/2 South Campbell</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ANDERSON</u>		b. (Middle) <u>HARRISON</u>		c. (Last) <u>SHULL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>October 16 1952</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>August 15, 1860</u>	9. AGE (In years last birthday) <u>92</u>	10. UNDER 1 YEAR Months _____ Days _____	11. OVER 1 YEAR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Richard R Shull</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Albright</u>		14. NAME OF HUSBAND OR WIFE <u>---</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs H F Groves, Springfield, Missouri</u>			
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>Arterio Sclerosis - Heart failure</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senile age 92</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION  <u>4500</u>				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 <u>Sept 7, 1952</u> , to <u>Oct 6, 1952</u> , that I last saw the deceased alive on <u>Oct 6, 1952</u> , and that death occurred at <u>6:00P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>[Signature]</u>				23b. ADDRESS <u>374 Linden Blvd</u>		23c. DATE SIGNED <u>10/18/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>OCT. 18, 1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>10-17-52</u>		REGISTRAR'S SIGNATURE <u>Edith Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Schmeyer</u>		ADDRESS <u>Springfield, Mo</u>	

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

0396

*Thomas*  
*314 Sanders*

**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 *James W. Wair*

Licensed Embalmer No. *4650*

P. O. Address *Springfield, 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.