

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9248**BIRTH NO. **APR 6 1953**REG. DIST. NO. **82**PRIMARY REG. DIST. NO. **4143**Registrar's No. **37**

1. PLACE OF DEATH a. COUNTY Cooper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cooper	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Blackwater		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Blackwater 0270	
c. LENGTH OF STAY (In this place) 6 months		d. STREET ADDRESS (If rural, give location) Streets not numbered	
d. FULL NAME OF HOSPITAL OR INSTITUTION Streets not numbered		d. STREET ADDRESS Streets not numbered	
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Stanard c. (Last) Shemwell		4. DATE OF DEATH (Month) (Day) (Year) March 29, 1953	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 7, 1868
9. AGE (In years) Last birthday 84	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	11. BIRTHPLACE (City and State or Foreign Country) Cooper County, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William D. Shemwell	13b. MOTHER'S MAIDEN NAME Lucy Platt	14. NAME OF HUSBAND OR WIFE -----	
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. None	17. INFORMANT'S SIGNATURE OR NAME Charlie Shemwell, Blackwater, 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) Cerebrum Pontate ANTECEDENT CAUSES with generalized metastases Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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 177X	
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 type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 10, 1953 , to March 29, 1953 , that I last saw the deceased alive on Feb 14, 1953 , and that death occurred at 3-15PM m., from the causes and on the date stated above.			
23a. SIGNATURE Dr. DeCicco		23b. ADDRESS Cooper Mo	
23c. DATE SIGNED 4/1/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE March 31, 1953	24c. NAME OF CEMETERY OR CREMATORY Arrow Rock cemetery	24d. LOCATION (City, town, or county) (State) Arrow Rock, Mo.
DATE REC'D BY LOCAL REG. 4/1/53	REGISTRAR'S SIGNATURE De Cooper	25. FUNERAL DIRECTOR'S SIGNATURE Campbell-Lewis Marshall, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

MAY 27 1957

MAY 27 1957

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 R. W. Campbell Jr.

Licensed Embalmer No. 3469

P. O. Address Marshall, 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.