

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31376

State File No.

FILED SEP 28 1953

BIRTH NO. _____ REG. DIST. NO. 93 PRIMARY REG. DIST. NO. 4153 Registrar's No. 53-84

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Dade</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Dade</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lockwood Mo</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Greenfield Mo</u> | |
| c. LENGTH OF STAY (In this place) <u>1wk</u> | | d. STREET ADDRESS (If rural, give location) <u>0</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Hospital</u> | | | |

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|--|--|---|--|---|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Claude</u> b. (Middle) _____ c. (Last) <u>Shipley</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 15, 1953</u> | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | |
| 8. DATE OF BIRTH <u>Mar, 1. 1872</u> | | 9. AGE (In years last birthday) <u>81</u> | | IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u> | | 11. BIRTHPLACE (State or foreign country) <u>Dade co Mo</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | |

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|--|--|---|--|---|--|
| 13a. FATHER'S NAME <u>George Shipley</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mary Shipley</u> | | 14. NAME OF HUSBAND OR WIFE <u>Osie Shipley</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>Martha Milligan Greenfield Mo.</u> | |

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|---|--|---|--|--|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i> | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u> | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> | | | | DUE TO (c) _____ | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension, Essential</u> | | | | | | 1 yr. | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |

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|---|--|---|--|--|--|
| 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>332 X</u> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | | 21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> 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 9-1, 1953, to 9-15, 1953, that I last saw the deceased alive on 9-15, 1953, and that death occurred at 4:30p m., from the causes and on the date stated above.

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|--|--|-----------------------------------|--|---|--|
| 23a. SIGNATURE (Degree or title) <u>Leah McNeely, MD</u> | | 23b. ADDRESS <u>Greenfield Mo</u> | | 23c. DATE SIGNED <u>9-21-53</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>9-17-53</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Collins</u> | |
| 24d. LOCATION (City, town, or county) (State) <u>Dade co Mo.</u> | | | | | |

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|---|--|---|--|--|--|
| DATE REC'D BY LOCAL REG. <u>9-22-53</u> | | REGISTRAR'S SIGNATURE <u>J. C. Canada</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W.R. Allison Greenfield MO</u> | |
|---|--|---|--|--|--|

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

0290

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 W.R. Allison

Licensed Embalmer No. 4404

P. O. Address Greenfield 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.