

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34049

State File No. ....

9291

FILED OCT 15 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. ....

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>ST. LOUIS, MISSOURI</b> )		c. CITY OR TOWN <b>Champaign</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>8 Days</b>		e. STREET ADDRESS (If rural, give location) <b>Champaign, Illinois</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Earl</b> b. (Middle) <b>P.</b> c. (Last) <b>SHAPLAND</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 26, 1953</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>March, 26, 1891</b>	9. AGE (In years last birthday) <b>62</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nelson Concrete Culvert</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Grigwood, Illinois /</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>John Shapland</b>		13b. MOTHER'S MAIDEN NAME <b>Co. Charlotte Page</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Lois Shapland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Robert Shapland, 511 S. Lynn</b> ADDRESS	

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 <b>11 months</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myasthenia Gravis</b>		
	ANTECEDENT CAUSES 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. <b>Pulmonary emphysema</b>		

19a. DATE OF OPERATION <b>9/25/53</b>	19b. MAJOR FINDINGS OF OPERATION <b>Tracheotomy--to relieve respiratory distress</b>		20. AUTOPSY? YES <input checked="" 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>7901</b>	

22. I hereby certify that I attended the deceased from **9/18**, 19**53**, to **9/26**, 19**53**, that I last saw the deceased alive on **9/26**, 19**53**, and that death occurred at **10:35P** m., from the causes and on the date stated above.

23a. SIGNATURE <b>FR Bradley</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>BARNES HOSPITAL</b>	23c. DATE SIGNED <b>9/27/53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>9-30-1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Sauveamin Cemetery</b>
		24d. LOCATION (City, town, or county) (State) <b>Livingston County, Ill.</b>

DATE REC'D BY LOCAL REG. <b>SEP 28 1953</b>	REGISTRAR'S SIGNATURE <b>VIA MOTOR J. Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Math Hermann &amp; Son, Inc. 2161 E. Fair Ave.</b> ADDRESS
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

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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.....  
Signature of Student Embalmer

Signed *Clement McHenry*.....

Licensed Embalmer No. *3732*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.