

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17663**

BIRTH NO. **FILED MAY 19 1954** REG. DIST. NO. **349** PRIMARY REG. DIST. NO. **4514** Registrar's No. **4**

1. PLACE OF DEATH a. COUNTY Sullivan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Sullivan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Green City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Green City	
c. LENGTH OF STAY (in this place) 51 yrs.		1050	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home in Green City		d. STREET ADDRESS (If rural, give location) No street address	

3. NAME OF DECEASED (Type or Print)	a. (First) Bertha	b. (Middle) Ellen	c. (Last) Shoop	4. DATE OF DEATH (Month) (Day) (Year) May 9, 1954
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Nov. 18, 1872	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months --- Days ---	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) School Teacher	10b. KIND OF BUSINESS OR INDUSTRY Education	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Adam Shoop	13b. MOTHER'S MAIDEN NAME Cyrena Shibley	14. NAME OF HUSBAND OR WIFE Never married
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Kathryn Shoop, Green City, Mo.	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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 9 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA of Breast		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? 170 X 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)
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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?
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22. I hereby certify that I attended the deceased from **May 1, 1954**, to **May 9, 1954**, that I last saw the deceased alive on **May 9, 1954**, and that death occurred at **3:30 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE R.D. Smith D.O.	(Degree or title)	23b. ADDRESS Green City, Mo.	23c. DATE SIGNED May 10, 1954
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 11, 1954	24c. NAME OF CEMETERY OR CREMATORY Green City Cemetery	24d. LOCATION (City, town, or county) (State) Green City, Mo.
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DATE REC'D BY LOCAL REG. 5/17/54	REGISTRAR'S SIGNATURE Agnes L. Page	504	25. FUNERAL DIRECTOR'S SIGNATURE Allen E. Hunt & Son, Green City, Mo.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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: *Karl R. Kent*

Licensed Embalmer No. *4689*

P. O. Address. *Green City, 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.