

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

State File No. **7133**

FILED APR 14 1955

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 93

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Diana</u> b. COUNTY <u>Wayne</u>	
b. CITY OR TOWN <u>Kirksville</u>	c. LENGTH OF STAY (In this place) <u>2 days</u>	c. CITY OR TOWN <u>Linnville</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF (If not in hospital institution, give street address or location) HOSPITAL OR INSTITUTION <u>Rucker Osted Hosp.</u>		e. STREET ADDRESS (If rural, give location) <u>P. F. D.</u> <u>8140</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Eva</u> b. (Middle) <u>May</u> c. (Last) <u>Shinn</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 1 1955</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6/6/90</u>	9. AGE (In years last birthday) <u>64</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 4 WKS: Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Wayne Co., Diana</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Julius Knight</u>	13b. MOTHER'S MAIDEN NAME <u>Mrs. Laughlin</u>	14. NAME OF HUSBAND OR WIFE <u>J. S. Shinn</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>R. F. Shinn</u>	ADDRESS <u>Linnville, Diana</u>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Circulatory Collapse</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Medullary Failure</u> DUE TO (c) <u>Overwhelming Toxemia</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>White Carcinoma of uterus and bowels</u> <u>Strangulated umbilical hernia 1991</u>			

19a. DATE OF OPERATION <u>3-31-55</u>	19b. MAJOR FINDINGS OF OPERATION <u>Adenocarcinoma of pelvis, strangulated umbilical hernia</u>	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>Linnville Diana</u>
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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?
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22. I hereby certify that I attended the deceased from 3-31, 1955, to 4-1, 1955, that I last saw the deceased alive on 3-31, 1955, and that death occurred at 6:30 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>James A. Graham M.D.</u>	23b. ADDRESS <u>800 W. Jefferson St. Kirksville, Mo.</u>	23c. DATE SIGNED <u>4-1-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>4-4-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Clio Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Clio Diana</u>
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DATE REC'D BY LOCAL REG. <u>4-2-55</u>	REGISTRAR'S SIGNATURE <u>Hate Lambert</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Greenlee Funeral Home Linnville, Mo.</u>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48

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..... *Robert B. Harris*

Licensed Embalmer No. *421*

P. O. Address *F. S. Hamill*

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.