

STANDARD CERTIFICATE OF DEATH

43231
STATE FILE NUMBER

FILED NOV 18 1957

Registration District No. 381 Primary Registration District No. 6175 Registrar's No. 117

V. S. 300
Rev. 1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Harris</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Harris</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lebanon Hosp.</u>			Length of stay in 1b <u>Life</u>	d. STREET ADDRESS (If outside, give location) <u>Lebanon Hosp.</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>CLAUDE</u> Middle <u>SHELTON</u> Last <u>DOOLIN</u>				4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1957</u>					
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-23-1875</u>		9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Sullivan Co Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Will H Doolin</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Johnson</u>		14. NAME OF HUSBAND OR WIFE <u>Ide Nell Neff Doolin</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>491-42-3839</u>	17. INFORMANT Address <u>Nathan Doolin Harris Mo</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>carcinoma of stomach</u>	DUE TO (c) <u>151X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)						
20c. TIME OF INJURY Hour <u>6</u> a.m. <u>p.</u> Month, Day, Year									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <u>8/15/57</u> , to <u>11/18/57</u> and last saw him alive on <u>10/11/57</u> Death occurred at <u>6 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Chas W. Doolin M.D.</u> (Degree or title)				22b. ADDRESS <u>Harris, Mo</u>		22c. DATE SIGNED <u>11/19/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burn</u>		23b. DATE <u>11-11-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Camp Ground Cem</u>		23d. LOCATION (City, town, or county) <u>Osgood Mo</u>		(State)		
24. FUNERAL DIRECTOR <u>PK Payne Son Galt mo</u>				25. DATE RECD. BY LOCAL REG. <u>11-12-57</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u>			

securing the medical certificate in this specific manner required by 1937-1940 Acts 1749.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

525
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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 *PK Payne Jr*

Licensed Embalmer No. *3400*

P. O. Address *Galt*

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.