

FILED FEB 3 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1949

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 54

300  
-57

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1. PLACE OF DEATH a. COUNTY <u>LIVINGSTON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>CARROLL</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		c. CITY OR TOWN <u>Bogard</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Susans Nursing Home</u>		Length of stay in lb <u>3 Days</u>	
d. STREET ADDRESS <u>city.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>AMELIA LENOYA SHIRLEY</u>			4. DATE OF DEATH Month Day Year <u>Jan-29-1958</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 21 - 1874</u>
9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>8</u>	
IF UNDER 24 HRS. Hours <u>0</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	
11. BIRTHPLACE (City and state or country) <u>St Charles County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>LEOPOLD SCHMIDT.</u>		13b. MOTHER'S MAIDEN NAME <u>DONT KNOW</u>	
14. NAME OF HUSBAND OR WIFE <u>Rufus Shirley</u>		Address <u>Bogard, Mo.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>ETHEL ROSE</u>		Address <u>Bogard, 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>Hypostatic Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Hemorrhage.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u> <u>2-3 wks.</u>
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 _____ a.m. _____ p.m. 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>1-27-58</u> to <u>1-29-58</u> and last saw her <sup>her</sup> <sub>him</sub> alive on <u>1-29-58</u> Death occurred at <u>11:00</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>R.W. Matheny D.O.</u>		22b. ADDRESS <u>Chillicothe, Mo.</u>	
22c. DATE SIGNED <u>1-30-58.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>Jan 31 - 1958</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SMITH</u>		23d. LOCATION (City, town, or country) (State) <u>Bogard Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>DICKERSON FUNERAL HOME Bogard Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1/30/58</u>	
26. REGISTRAR'S SIGNATURE <u>Francis B Neece</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *P. M. Marshall, Jr.* .....

Licensed Embalmer No. *4469* .....  
P. O. Address *Carrollton* .....

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.