

Health,
& Welfare
Public
Service

FILED MAY 7 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-017047

STATE FILE NUMBER

Registration District No. 340

Primary Registration District No. 4503

Registrar's No. 44

300
1-57
030

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bernie</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Bernie</u> <u>1030</u> 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>Home</u>		Length of stay in lb Years: _____	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>William Elbert Shipp</u>			4. DATE OF DEATH Month Day Year <u>April 16, 1958</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 15, 1875</u>	9. AGE (In years last birthday) <u>82</u>	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) <u>Farm</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	11. BIRTHPLACE (City and state or country) <u>Arkansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>George Shipp</u>	13b. MOTHER'S MAIDEN NAME <u>Jane Shipp</u>	14. NAME OF HUSBAND OR WIFE <u>Vitha Ann Shipp</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Madge Cooper</u>	Address <u>Bernie, Mo.</u>
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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>Broncho Pneumonia (Including Capillary Bronchitis)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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>Arterio Sclerosis</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.) <u>491X</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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20d. INJURY OCCURRED WHILE AT <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 _____
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21. I attended the deceased from April 2, 1958 to April 16, 1958 and last saw ^{her}him alive on April 16, 1958
Death occurred at 4:45 P. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>F. O. Jenkins</u> (Degree or title) <u>D.O.</u>	22b. ADDRESS <u>Bernie, Mo.</u>	22c. DATE SIGNED <u>4-18-1958</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-19-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Luie Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Clinton, Arkansas</u>
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24. FUNERAL DIRECTOR <u>Duffie</u> ADDRESS <u>Bernie, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4-30-58</u>	26. REGISTRAR'S SIGNATURE <u>Delma D. Jenkins</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 *Raymond L. Duffie*

Licensed Embalmer No. *4798*

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