24611

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 11 19[illegible]

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 51 — Primary Registration District No. 5182 — Registrar's No. 24

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Rural Shamrock
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
R.F.D. No. 1 Jackson Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
(Specify whether
In this community about 50 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cape Girardeau
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. No. 1 Jackson Mo.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME William Franklin Shoulte
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Myra E. Shoulte
6. (c) Age of husband or wife if alive years

7. Birth date of deceased May (Month) 29 (Day) 1862 (Year)

8. AGE: Years 81 | Months 2 | Days — | If less than one day hr. min.

9. Birthplace Cape Gir. (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name Franklin Shoulte
13. Birthplace (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Jane Colmer
15. Birthplace Cape Gir. (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant's own signature Mrs Walter Sides
(b) Address R.F.D No 1 Jackson Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Old Appleroth Ceme

18. (a) Signature of funeral director Reidelbächler & Butz
(b) Address Pocahontas Mo

19. (a) 7-29-43 (Date received local registrar) (b) Henry A Butz (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29
year 1943 hour 8 AM minute — M.

21. I hereby certify that I attended the deceased from July 22, 1943 to July 29, 1943
that I last saw him alive on July 26, 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Lobar Pneumonia	2 days
Due to Cold	
Due to	
Other conditions Arteriosclerosis (Include pregnancy within 3 months of death)	10 yrs

Major findings:
Of operations 108
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. L. Lenhardt (M. D. or other)
Address Jackson Mo Date signed 7-29-43

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
REV. 6-1-39 1 X 19511

RECEIVED

District Health Officer No. 4

District File Number 843-254

Date Filed 8-9-43

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~~ .....

....., Registered Apprentice No. .....

working under my personal supervision.

Signed Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson 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, above space should be left blank.