MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Scott

Township Benland

or

Village

or

City (NO. , St.; Ward)

Registration District No. 421 File No. 40128

Primary Registration District No. 6070 Registered No. 96

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Jacob Ships

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

DATE OF BIRTH: Don't Know Month (Month) (Day) 1862 (Year)

AGE: 59 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Massacklee Del

PARENTS

NAME OF FATHER: Wm Shipley

BIRTHPLACE OF FATHER (City or town, State or foreign country): Del

MAIDEN NAME OF MOTHER: Wm Shipley

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Del

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Ships

(ADDRESS) Dexter Mo.

Filed Nov 8, 1911 J. A. Nickens REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov (Month) 7 (Day) 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 3, 1911, to Nov 8, 1911, that I last saw him alive on Nov 7, 1911, and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH* was as follows:

Bronchitis & Heart Failure

1 Day

(Duration) yrs. mos. ds.

Contributory —
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) J. W. Miller M. D.

Nov 8, 1911 (Address) Dexter Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death? —

Former or usual residence —

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mineral Switch Mo	Nov 9, 1911
UNDERTAKER	**ADDRESS**
John Albritton	Dexter Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH _____ (Month) _____ (Day), 1_____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191_____, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day), 191_____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191_____, to _____, 191_____, that I last saw h_____ alive on _____, 191_____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____ (SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191_____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL _____, 191_____

UNDERTAKER | ADDRESS