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

PLACE OF DEATH

County Clinton

Township Clinton
or
Village
or
City (NO. , St.; Ward)

Registration District No. 207 File No. 12909

Primary Registration District No. 5287 Registered No. 10

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

FULL NAME Herschall Thurston Shanks

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH Mar (Month) 24 (Day), 1912 (Year)

AGE yrs. mos. 10 ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work None Infant
(b) General nature of industry, business, or establishment in which employed (or employer) Infant

BIRTHPLACE (City or town, State or foreign country) Clinton, Co, Mo

PARENTS

NAME OF FATHER John A Shanks

BIRTHPLACE OF FATHER (City or town, State or foreign country) Clay Co. Mo

MAIDEN NAME OF MOTHER Julia Brooks

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. Shanks

(ADDRESS) Holt Mo

Filed Apr 8", 1912. Frank H Fulton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April (Month) 2 (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Mar. 24, 1912, to Apr 2, 1912, that I last saw him alive on Apr 2, 1912, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Hepatitis

1610 151

(Duration) yrs. mos. 10 ds.

Contributory (SECONDARY) Icterus

(Duration) yrs. mos. 10 ds.

(Signed) H L Tadlock M. D.

Apr 2, 1912 (Address) Holt, 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 Lathrop

DATE OF BURIAL April 4, 1912

UNDERTAKER L. Fry.

ADDRESS Holt Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward)

[If death occurr hospital or inst give its NAME of street and num

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

_____, *1* _____
(Month) (Day) (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

_____, *1*
(Month) (Day) (

I HEREBY CERTIFY, that I attended deceased

_____, 191___, to _____, 19

that I last saw h_____ alive on _____, 19

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____

(Signed) _____

_____, 191___ (Address) _____

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

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

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

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 19
UNDERTAKER	ADDRESS

"Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc. of ..... (name origin; "Cancer" is less definite; avoid