LOCAL REGISTRAR'S REPORT DO NOT TEAR LEAF OUT

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

30971

V. S. No. 2.

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PLACE OF DEATH

County: Dade — Registration District No.: 236 — File No.:

Township: Rock Prairie — Primary Registration District No.: 5321 — Registered No.: 16

City: (No. St., Ward)

FULL NAME: Georgie Mathias Shirk

(a) Residence. No. Everton St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): single

MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF: Child

DATE OF BIRTH (MONTH, DAY AND YEAR): 8-29-20

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
2		1	4	

OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Everton Mo

10. NAME OF FATHER: Vint Shirk

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Everton Mo

12. MAIDEN NAME OF MOTHER: Cardie Mallary

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Everton Mo

INFORMANT: L E Shirk

(Address): Everton Mo

FILED Nov 4, 1922 W. R. Riley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov 3 1922

17. I HEREBY CERTIFY, That I attended deceased from Nov 3, 1922, to Nov 3, 1922, that I last saw h alive on Nov 3, 1922 and that death occurred, on the date stated above, at 11 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Membranous Croup

Diphtheria

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): None

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED: Home

IF NOT AT PLACE OF DEATH? Home

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Dep. Cy. B

(Signed) W. R. Riley, M. D

11/4, 1922 (Address) Everton Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Antioch Ch — DATE OF BURIAL: Nov 4 1922

20. UNDERTAKER: H H Hembree — ADDRESS: Everton Mo

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No. ....., ... St. .....

2. FULL NAME .....

(a) Residence. No..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I attended deceased from .....,19....., to .....
that I last saw h..... alive on....., 19..
death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed).....
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL

20. UNDERTAKER | ADDRESS

A. G. Hembree

I CERTIFY, That I attended the deceased person named above; that I last saw him alive on the date stated above; and that to the best of my knowledge and belief death occurred at the time, date, place and from the cause stated above.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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V. No. 2