

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

Do not use this space.

1611

**1. PLACE OF DEATH**

County Lafayette  
Township Driver  
City Higginsville Mo (No. ....)

Registration District No. 466  
Primary Registration District No. 2623-B

File No. ....  
Registered No. 12 St. .... Ward)

**2. FULL NAME**

Sarah J. Shackelford

(a) Residence No. .... St., .... Ward.

(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 5 1846

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ....hra. or ....min.  
90 2 18

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Colatan, Texas  
(STATE OR COUNTRY) Texas Co.

10. NAME OF FATHER Do not know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Do not know  
(STATE OR COUNTRY) .....

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Do not know  
(STATE OR COUNTRY) .....

14. INFORMANT Mrs Phillips, Home.  
(Address) Higginsville Mo

15. FILED 1-24 1927 Bessie P. Porter  
REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 23<sup>rd</sup> 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan 16<sup>th</sup> 1927, to Jan 23<sup>rd</sup> 1927, that I last saw her alive on Jan 22<sup>nd</sup> 1927 and that death occurred, on the date stated above, at 9:30 P.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Bronchial Pneumonia  
10717  
10681000  
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (SECONDARY) Cold + Coriza  
(duration) yrs. mos. 8 ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH: .....

1) DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physician

(Signed) J.H. Porter, M. D.

, 19 (Address) Higginsville 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.

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

Confederate Home Cem. Jan 25 1926  
20. URBERTAKER ADDRESS

W.H. Lader Higginsville Mo

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

1927

