JAN 4 1928

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

Do not use this space.

33259

File No. .....

Registered No. 16

1. PLACE OF DEATH

County Greene — Registration District No. 321

Township Clay — Primary Registration District No. 3444

City Galloway (No. Galloway Mo St. ..... Ward)

2. FULL NAME J. M. Shockley

(a) Residence. No. ..... St. ..... Ward. ..... (If nonresident give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: wh

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

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Viola Shockley

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 2-1865

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
62	1	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Laclede Co
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Unknown

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 John Shockley
(Address) Galloway Mo

15. FILED 11-20 1927 Wm L. Linn
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/19 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 1A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
82A
97 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Arterio Sclerosis
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? 740L
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Jewell E. Wright Coroner M.D.
11/21 1927 (Address) Springfield 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: Sparta Mo — DATE OF BURIAL: 11/23 1927

20. UNDERTAKER: Alma Lohmeyer — ADDRESS: 534 St Louis

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.

...ADING INK—THIS IS A PERMANENT RECORD