

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

Do not use this space.

1. PLACE OF DEATH

County... Boone
Township... Center
City... Greenfield (Name)

Registration District No. 237
Primary Registration District No. 4144

File No. 12738
Registered No. 13
St. _____ Ward _____

2. FULL NAME

(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) married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE OF R. J. Shipley

6. DATE OF BIRTH (MONTH, DAY AND YEAR) april 7-1843

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
83 0 0

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 employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Polk Co Mo

PARENTS

10. NAME OF FATHER Pharo Cook

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

12. MAIDEN NAME OF MOTHER Mary McElhine

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

14. INFORMANT R. J. Shipley
(Address) Greenfield Mo

15. FILED 4-12-28 E. Ball REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 7 1928

17. I HEREBY CERTIFY That I attended deceased from March 3, 1928, to Apr 7, 1928 that I last saw her alive on Apr 7, 1928, and that death occurred, on the date stated above, at 11 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Accident (Fractured hip)
181 A
194 B
167 (duration) yrs. 2 mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH. DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Geo L. New, M. D.

, 19 (Address) Greenfield 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 Greenfield Mo DATE OF BURIAL april 8 1928

20. (UNDERTAKER) A. Ward ADDRESS Greenfield 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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Wade Registration District No. 237 File No.
 Township Greenfield Primary Registration District No. 7144 Registered No. 12
 City Greenfield (No.) St. Ward)

2. FULL NAME

Nancy E Shipley
 (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. da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M
(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)

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 4-12-28 E. Ball
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 7 19 28

17. I HEREBY CERTIFY That I attended deceased from 19....., 19....., and 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:

Accident (Fractured hip)

a fall (duration) yrs. 2 mos. ds.

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

18. WHERE WAS DISEASE CONTRAINDICATED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D.

, 19 (Address)

*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

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. A JE 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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-12738