

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

Do not use this space.

30662

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_  
Towship Haw Primary Registration District No. \_\_\_\_\_  
City Kansas City (No. St. Mary's Hosp.) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 3073  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Mr. William S. Shockley

(a) Residence. No. 3301 Forest St. 13 Ward \_\_\_\_\_  
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widowed  
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 20, 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
60 6 4

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Timer  
(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) Mo

10. NAME OF FATHER Benj. Shockley

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

12. MAIDEN NAME OF MOTHER Amanda Brock

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

14. INFORMANT Ralph O. Shockley (Address) 14507 Wornall

15. FILED 9/24 19 28 M. M. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 24 19 28

17. I HEREBY CERTIFY That I attended deceased from Sept 20, 1928, to Sept 24, 1928? that I last saw him/her alive on Sept 23, 1928, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

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

Diabetic mellitus  
59  
unknown (duration) yrs. mos. da.

CONTRIBUTORY Diabetic coma (SECONDARY) (duration) yrs. mos. 4 da.

18. WHERE WAS DISEASE CONTRACTED 57 IS NOT AT PLACE OF DEATH? no

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Laboratory (Signed) Bredgwater, M. D.

(Address) 1010 Chambers Bldg

\*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 Forest Hill DATE OF BURIAL 9-26 19 28

20. UNDERTAKER L. N. Newcomer ADDRESS Donohoe

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.

WHILE FILING, WITH ENFACING INSTRUMENTS IS A PERMANENT RECORD

1010 Chambers Alley.  
m 5582.  
2-5.