

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

Do not use this space.

33041

1. PLACE OF DEATH -

County Chariton Registration District No. 176 File No. _____
 Township Linn Primary Registration District No. 410J Registered No. 8
 City Burns (No. _____) St. _____ Ward _____

2. FULL NAME William Shouse
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Married
 (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Willie Ann Patton Shouse
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 9, 1867
7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. min.**
60 3 27 — — —

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

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

10. NAME OF FATHER B.A. Shouse

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

12. MAIDEN NAME OF MOTHER Isabell Ansell

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

14. INFORMANT B.F. Shouse
 (Address) Burns Mo.

15. FILED Oct 7, 1928 A.R. Lewis
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 28, 1928

17. I HEREBY CERTIFY That I attended deceased from _____, 1928, to _____, 1928, and that I last saw him alive on _____, 1928, and that death occurred, on the date stated above, at _____ in.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Tumor

55 (duration) Several months

CONTRIBUTORY (SECONDARY) Fracture of Skull
 (duration) 2 1/2 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

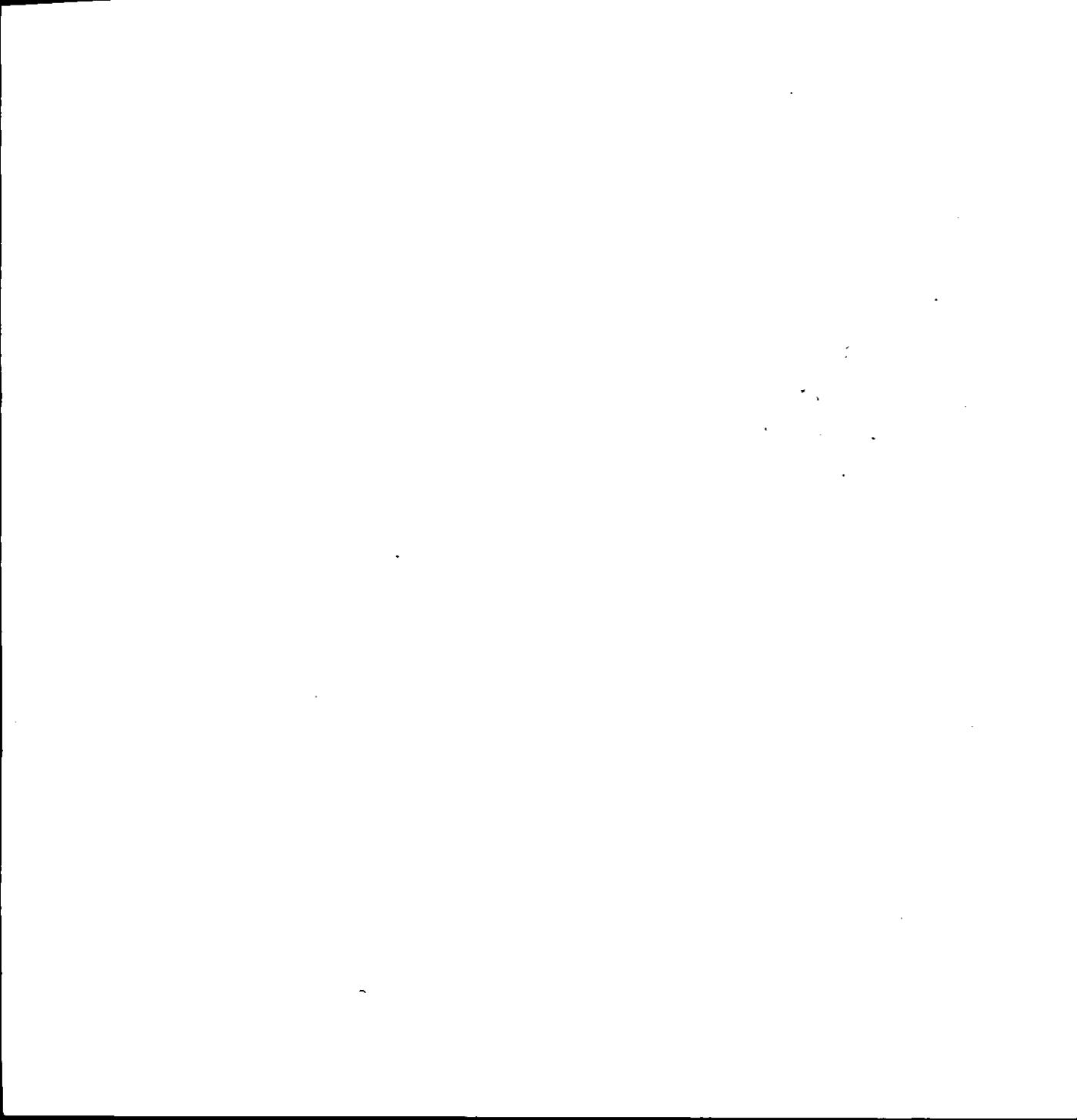
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical Examinations
 (Signed) J.M. Harrell M.D.
Oct 6, 1928 (Address) Burns 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 2003 Cemetery **DATE OF BURIAL** Oct. 8, 1928

20. UNDERTAKER J.P. Thorne **ADDRESS** Burns Mo.



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Chariton Registration District No. 176 File No.
Township Sumner Primary Registration District No. 4105- Registered No. 8
City Sumner (No.) St. Ward)

2. FULL NAME William Shouse

(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. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 9, 1867

7. AGE YEARS MONTHS Days If LESS than 1 day, hrs. or min.
61 1 27

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 12/10/28 A. C. Lewis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 6, 1928

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (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?.....

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

SUPPLEMENTARY

S-33041