

NOV 22 1928

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

Do not use this space.

35776

1. PLACE OF DEATH

County... *Shelby*  
Township... *East Butler*  
City... *Shelbina* (No. ....) St. .... Ward)

Registration District No. *830*  
Primary Registration District No. *6091*

File No. *38*  
Registered No. ....

2. FULL NAME *Matilda Shelton Dye*

(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. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *William Henry Dye*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 23 1849*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ... hrs. ... min.  
*78 10 5*

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) *175*  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Hannibal Mo* (STATE OR COUNTRY)

10. NAME OF FATHER *John Shelton*

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

12. MAIDEN NAME OF MOTHER *Rhoda Henniger*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Don't know* (STATE OR COUNTRY)

14. INFORMANT *Joe Berner* (Address) *Shelbina, Mo*

15. FILED ..... 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 *Oct 11 1928* to *Oct 28 1928* that I last saw her alive on *Oct 28 1928*, and that death occurred, on the date stated above, at *4 A.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS: *Carcinoma of Liver*  
*Had been in poor health for some months*

CONTRIBUTORY *Advanced age - started* (SECONDARY) *Accident* (duration) *2 1/2 over 12 1/2*

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

DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *Oct 25 1928*  
WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? *Operation Shows*  
(Signed) *J. D. Smith* M.D.  
*Shelbina Mo* (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 *ROP* DATE OF BURIAL *Oct 30 1928*

20. UNDERTAKER *E Hayes Shelbina* ADDRESS

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.

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eds ...

—Every list of ...  
OF DEATH in

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

10-28  
ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Shelby Registration District No. 830 File No. 38  
Township Salt River Primary Registration District No. 6091 Registered No. \_\_\_\_\_  
City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Matilda Shelton Dye  
(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. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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 \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.  
(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 Nov 10 1925 Madge Joach REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 28 1925

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

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

19

20. UNDERTAKER

ADDRESS

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

K. B. ... information should be carefully supplied. AGE ... should be stated EXACTLY ... Cause of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION OF DEATH very important.

SUPPLEMENTARY

S-35776