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

Do not use this space.

37316

File No. .....

Registered No. .....

1. PLACE OF DEATH

County: Jasper — Registration District No.: 415

Township: Sarcoxie — Primary Registration District No.: 4247

City: Reeds (No. ....., ... St. ..... Ward)

2. FULL NAME Mrs. Clara Adell Shue

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF H. P. Shue

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 10 - 1860

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	6	11	

8. OCCUPATION OF DEECEASED
(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) Bellevadier
(STATE OR COUNTRY) Ill.

PARENTS

10. NAME OF FATHER Dr. Reynolds
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

14. INFORMANT Mahlon Shue
(Address) Reeds, Mo.

15. FILED 11/22, 1928 Geo. H. Brayton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 21 1928

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1928, to Nov 21, 1928, that I last saw h. alive on Nov 20, 1928, and that death occurred, on the date stated above, at 8:15 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Nephritis.

(duration) 1 yrs. 3 mos. ..... ds.

CONTRIBUTORY (SECONDARY) Pulmonary T.B.

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

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? Laboratory
(Signed) Lray Simmons, M. D.
Nov 22, 1928 (Address) Sarcoxie 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	DATE OF BURIAL
Sarcoxie Cemetery	Nov 25 1928
20. UNDERTAKER	**ADDRESS**
Knell Mortuary	Carthage

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.