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

Do not use this space.

5988

1. PLACE OF DEATH
County: DeKalb
Township: Adams
City: Weatherby
Registration District No. 263
Primary Registration District No. 5365
File No. 6
Registered No. 8
No. ..... St. ..... Ward)

2. FULL NAME: Nancy Bell Shellman
(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 12 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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 OF~~ (OR) WIFE OF: R. B. Shellman

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb 5 1860

7. AGE: Years 69; Months; Days 19; If LESS than 1 day, ... hrs. or ..... min.

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): Albany
(STATE OR COUNTRY): Kentucky Clinton Co.

PARENTS

10. NAME OF FATHER: Chas Sloan
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Albany
(STATE OR COUNTRY): Kentucky Clinton Co.
12. MAIDEN NAME OF MOTHER: Cyrana Davis
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Albany
(STATE OR COUNTRY): Kentucky Clinton Co.

14. INFORMANT: Fay S. Shellman
(Address)

15. FILED 2/27 19..... J. F. Hedrick M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 2/24 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928, to Feb 24, 1929 that I last saw her alive on Feb 24, 1929, and that death occurred, on the date stated above, at 4 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar pneumonia
Paralysis of left side
(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY): paralysis
(duration) 2 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) J. F. Hedrick, M.D.
2/27, 1929 (Address) Weatherby, 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: Hambaugh
DATE OF BURIAL: 2/27 1927

20. UNDERTAKER: [illegible]
ADDRESS: Maysville, 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.

MAR 21 1929

WHITE PAINT, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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