

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

Do not use this space.

11051  
11001

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_  
 Township Kear Primary Registration District No. 29849  
 City N. C. Mo. (No. Felbours Consolidated Home St. \_\_\_\_\_ Ward \_\_\_\_\_)

File No. 1562  
 Registered No. \_\_\_\_\_

**2. FULL NAME**

Lebbie Shaw  
 (a) Residence. No. 1014 East 26th St. 4 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 \_\_\_\_\_ 4. COLOR OR RACE \_\_\_\_\_ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) \_\_\_\_\_

Female White Widow

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

Andrew J. Shaw

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

July 15 - 1845

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

83 | 8 | 14 | \_\_\_\_\_

**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 \_\_\_\_\_

Housewife

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Canada

**10. NAME OF FATHER**

Ryle

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) No record

**12. MAIDEN NAME OF MOTHER**

No record

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) No record

**14.**

INFORMANT Ada Sitzer  
 (Address) 1014 East 26th St

**15.**

FILED 3/30 1929 M. M. Connel REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 29 - 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1929, to Mar 29 1929, that I last saw her alive on Mar 26 1929, and that death occurred, on the date stated above, at 6 AM m.

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

arteriosclerosis

CONTRIBUTORY (SECONDARY)

97 910

(duration) 10 yrs. mos. ds.

(duration) \_\_\_\_\_ 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? Clinical

(Signed) W. L. Ray, M. D.

Mar 30, 1929 (Address) 321 Altman 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 DATE OF BURIAL

Dimmiton Texas Mar 1929

20. UNDERTAKER

ADDRESS

Mrs. C. L. Forster N. C. 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.

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3  
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