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

Do not use this space.

14648

399

1002

File No. 6909

Registered No. 1909

1. PLACE OF DEATH
County: Jackson
Township: Kansas
City: Kansas City (No. 3626 Michigan St. Ward)
Registration District No.
Primary Registration District No.

2. FULL NAME: Lilla May Sheckley

(a) Residence. No. 3626 Michigan St. 13 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug. 25, 1888

7. AGE: Years 40 | Months 7 | Days 13 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): Belleville
(STATE OR COUNTRY): Ill.

PARENTS

10. NAME OF FATHER: P. H. Sheckley

11. BIRTHPLACE OF FATHER (CITY OR TOWN): St. Louis
(STATE OR COUNTRY): Mo.

12. MAIDEN NAME OF MOTHER: Lilla A. Holland

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Johnstown
(STATE OR COUNTRY): Penn.

14. INFORMANT: Mrs. Lilla A. Sheckley
(Address): 3626 Michigan

15. FILED 4/8, 1929 M. M. Cerfue
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): April 8 1929

17. I HEREBY CERTIFY, That I attended deceased from 4-5-29, 19, to 4-8-29, 19, that I last saw h. alive on 4-7-29, 19, and that death occurred, on the date stated above, at 1:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary edema 95 A
following cerebral 82 A
embolism 111 B

X (duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY): M. Kurtdrune

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? No
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) L. Conrey, M. D.
4/8, 1929 (Address) 638 Linwood Blvd.

*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: Forest Hill

DATE OF BURIAL: 4/9 1929

20. UNDERTAKER: W. Newcomer's Son

ADDRESS: K.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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Vic. 4478.
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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County: Jackson — Registration District No. ..... File No. .....

Township: Kaw — Primary Registration District No. ..... Registered No. 1689

City: K. C. Mo. (No. ....., ... St. ..... Ward)

2. FULL NAME Lilla May Shickley

(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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): S

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 .....
(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)

PARENTS

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 4/8, 19 29 M. M. Crane
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 8 19 29

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19..., 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:
Cerebral Hemorrhage
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Chr Heart Disease
..... (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) T. J. Lowrey, 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

SUPPLEMENTARY

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

...p supplied. AGE should be stated EXACTLY. PHYSICIANS should state ...m., so that it may be properly classified. Exact statement of OCCUPATION is very important.

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