24 1929

42
9
2

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.

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

Do not use this space. 24410

1. PLACE OF DEATH Windsor Mo
County Henry, Registration District No. 14
Township, Primary Registration District No. 4211
City Windsor Mo (No. ..... St. ..... Ward)
File No. .....
Registered No. 26

2. FULL NAME Richard Lealand Shadburne, M.D.
(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 Male
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 married
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 19 1850
7. AGE 78 YEARS 4 MONTHS 4 DAYS If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Physician
(b) General nature of industry, business, or establishment in which employed (or employer) Retired Physician
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) Troy Missouri
(STATE OR COUNTRY) Missouri

PARENTS
10. NAME OF FATHER Thomas G. Shadburne
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Mary Elizabeth Jones
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Troy
(STATE OR COUNTRY) Missouri

14. INFORMANT John T. Shadburne
(Address) Windsor Mo.
15. FILED July 16, 1929 J. Jennings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 15 1929
17. I HEREBY CERTIFY, That I attended deceased from July 3, 1929, to July 15, 1929, that I last saw him alive on July 15, 1929, and that death occurred, on the date stated above, at 8:20 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
~~Reg~~ Left Side
(duration) ..... yrs. ..... mos. 12 ds.
CONTRIBUTORY (SECONDARY) 74 A
(duration) ..... yrs. ..... mos. ..... ds.
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
0 DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) T. A. Blackmore, M. D
7-15, 1929 (Address) Windsor, 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 Windsor
DATE OF BURIAL July 16 1929
20. UNDERTAKER C. A. Roof
ADDRESS Windsor Mo.

No Burnt Port