

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

Do not use this space.

30617

1. PLACE OF DEATH

County Greene Registration District No. 944
 Township Stafford Primary Registration District No. 5447B
 City Stafford R# 2

File No. 17
 Registered No. 17
 St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Stafford Mo R# 2 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sep 12 - 1864

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
65 | 0 | 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Ohio
 (STATE OR COUNTRY)

10. NAME OF FATHER Marion E. Shipley

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Nancy F. Campbell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ohio
 (STATE OR COUNTRY)

14. INFORMANT Francis Pierce
 (Address) _____

15. FILED Oct 6, 1929 G. B. Grier
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 25 1929

17. I HEREBY CERTIFY That I attended deceased from Sept. 25, 1929 to Sept. 25, 1929
 that I last saw h. ex alive on Sept. 25, 1929, and that death occurred, on the date stated above, at 3 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicemia
30 (duration) _____ mos. 5 da.
 CONTRIBUTORY Perforated Fingers
 (SECONDARY) (duration) _____ yrs. mos. 9 da.

18. WHERE WAS DISEASE CONTRACTED Home
 IF NOT AT PLACE OF DEATH. _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No.

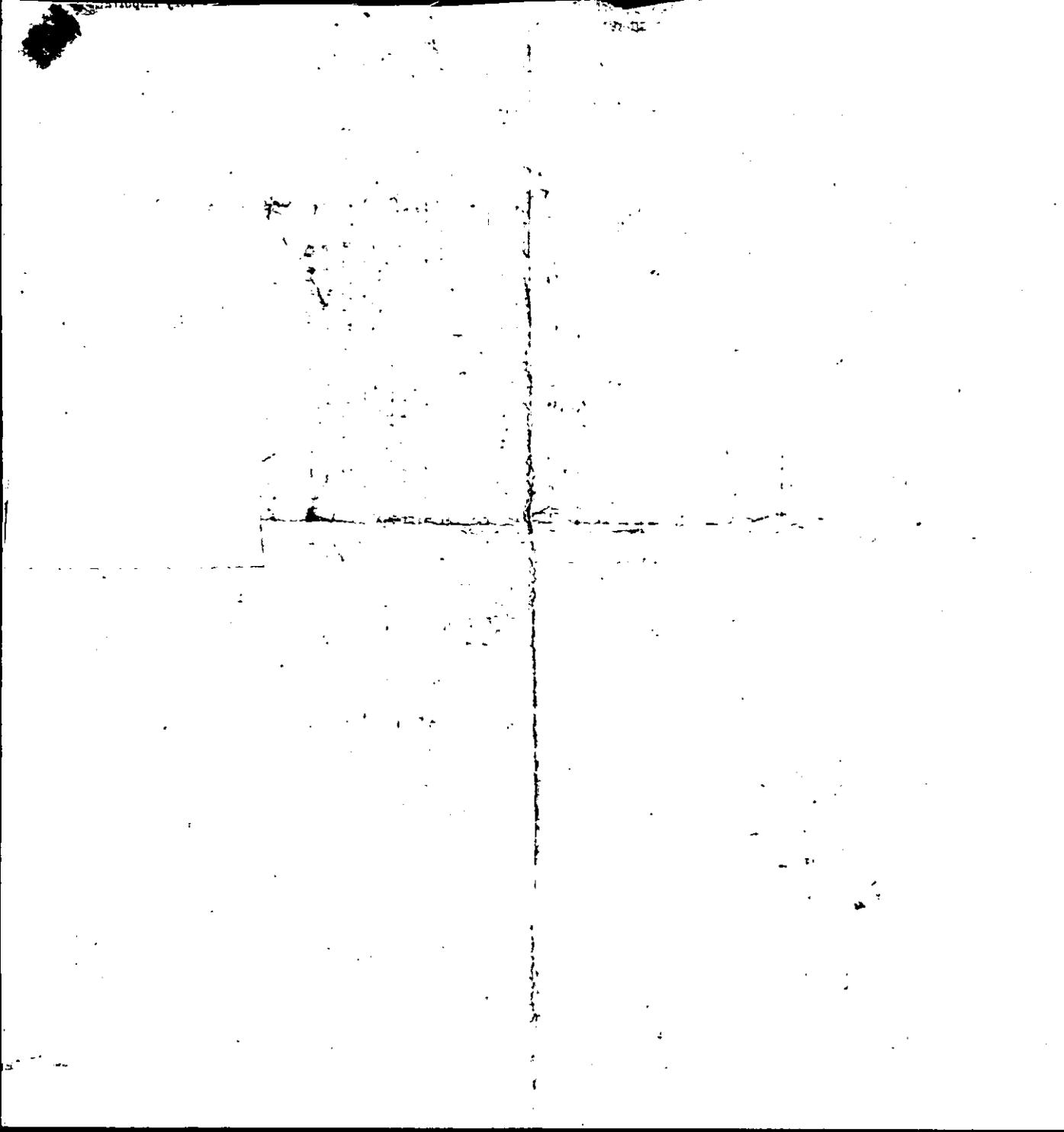
WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) R. H. Focht M. D.

(Address) Stafford 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 Bassville Cemetery DATE OF BURIAL Sep 27 1929

20. UNDERTAKER J. W. Klingner ADDRESS Springfield, Mo



**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 Greene
Township Jackson
City (No. _____) _____ St. _____ Ward _____

Registration District No. 944
Primary Registration District No. 3447B

File No. _____
Registered No. 17
St. _____ Ward _____

2. FULL NAME

Mary Jane Meshburn

(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) wid

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 _____ (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) yrs. mos. ds.
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

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 6-29 OB Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 25 1929

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:

Septicemia
CONTRIBUTORY (SECONDARY) degenerated finger (duration) yrs. mos. ds.
Recepted by mail (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED which drunk
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? 47

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, 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 _____

20. UNDERTAKER _____ ADDRESS _____

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

SUPPLEMENTARY

