

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

Do not use this space.

32824

1. PLACE OF DEATH

County Wayne
Township Cedar Creek
City (No. _____) _____

Registration District No. 1169
Primary Registration District No. 6195B

File No. _____
Registered No. 71
St. _____ Ward _____

2. FULL NAME

Mrs. Alanzo Shearer

(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 26 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 3 1903

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>26</u>	<u>1</u>	<u>12</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer self

9. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY) Wayne Co Mo

10. NAME OF FATHER Robert Shearer

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Wayne Co Mo

12. MAIDEN NAME OF MOTHER Nettie White

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Wayne Co Mo

14. INFORMANT Frank Shearer
(Address) Pellerson, Mo.

15. FILED 9-16-1929 REGISTRAR Mrs C.H. Jones

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-15-1929

17. I HEREBY CERTIFY, That I attended deceased from 9-14-1929 to 9-14-1929
that I last saw him alive on 9-14-1929 and that death occurred, on the date stated above, at 10 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Intestinal obstruction

12 1/2 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) _____
(duration) yrs. mos. da.

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

0 DID AN OPERATION PRECEDE DEATH? No DATE OF had him to hospital for operation for 10 wks.
WAS THERE AN AUTOPSY? No no

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) C.H. Jones M. D.
, 19 (Address) Brunot, 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 Wood Cemetery DATE OF BURIAL 9-16-1929

20. UNDERTAKER Marsh Wilkinson ADDRESS Kennett, Mo.

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.

PARENTS

CAUSE OF DEATH

1901

1902

1903

1904

REGISTRATION IN THIS DISTRICT

**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 Wayne Registration District No. 1169 File No. _____
 Township Center Creek Primary Registration District No. 6195 Registered No. _____
 City _____ (No. _____) St. _____ (Ward _____)

2. FULL NAME

Joe Giorgio Shearer
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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) _____

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 9-16 1929 Mrs CH Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 15 1929

17. I HEREBY CERTIFY That I attended deceased from _____ 19____ to _____ 19____ that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Intestinal obstruction
which was not post mortem
and was known to
cause of death (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

(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) C. Jones, M. D.

1122 1929 (Address) Brumby Ave

*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 _____

Woods Cemetery 9-16 1929

20. UNDERTAKER _____

ADDRESS _____

Marsh Wilkinson, Greenville Mo

THIS IS A PERMANENT RECORD
 INFORMATION SHOULD BE CAREFULLY SUPPLIED
 AGE SHOULD BE STATED EXACTLY
 EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT
 ALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE

SUPPLEMENTARY

S-32824