

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

Do not use this space.

F. M. Wright
File No. **36922**
Registered No. **8.1**
St. _____ Ward _____

1. PLACE OF DEATH

County *Linn* Registration District No. *318*
Township _____ Primary Registration District No. *2027*
City *Springfield* (Name) *St. Johns Hospital*

2. FULL NAME

(a) Residence. No. *Linn Creek Mo., R#3 Box 56* St. _____ Ward _____
(Usual place of abode)

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 MEDICAL CERTIFICATE OF DEATH

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 *Mary J. Shivers*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 16-1866*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
63 8 12

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

9. BIRTHPLACE (CITY OR TOWN) *Mo.* (STATE OR COUNTRY)

10. NAME OF FATHER *John Shivers*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *L. Shivers* (Address) *Linn Creek Mo.*

15. FILED *11-25-24* 19 *24* *Lon Sharp* REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) *11/28* 19 *29*

17. I HEREBY CERTIFY, That I attended deceased from *Nov 24*, 19 *29* to *Nov 28*, 19 *29* that I last saw him alive on *Nov 28*, 19 *29*, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Peritonitis following Gastric for Rupture of Stomach 1941

CONTRIBUTORY (SECONDARY) *as above*

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: *banden Co*

1. DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *11/24/29*

WAS THERE AN AUTOPSY? *No*
WHAT TEST CONFIRMED DIAGNOSIS? *of Gastric*
(Signed) *F. M. Wright* M. D.

11/29 (Address) *Springfield 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 *Linn Creek Cemetery* DATE OF BURIAL *Nov 30 19 29*

20. UNDERTAKER *J. H. Klingner & Co.* ADDRESS *424 E. 1st St. Springfield, Mo.*

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Llano Registration District No. 318 File No. _____
 Township _____ Primary Registration District No. 2001 Registered No. 871
 City Spaced (No. _____) St. _____ Ward _____

2. FULL NAME

James H. Shivers
 (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 1/29 1928 For Sharp
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/28 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:

Peritonitis following operation for rupture of stomach caused by lifting a log at gym 1 week

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) _____, 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 _____

SUPPLEMENTARY

120

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED. Exact state. REGISTRATION DISTRICT NO. 318. COUNTY OF LLANO. MISSOURI. ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY. REGISTERED NO. 871. DATE OF DEATH 11/28 1929. FULL NAME James H. Shivers. PLACE OF DEATH Spaced. OCCUPATION OF DECEASED Peritonitis following operation for rupture of stomach caused by lifting a log at gym 1 week. CAUSE OF DEATH Peritonitis following operation for rupture of stomach caused by lifting a log at gym 1 week. DATE OF BURIAL _____.

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