

MAR 25 1930

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

Do not use this space.

4384

1. PLACE OF DEATH

County Christian Registration District No. 184
Township Highland Primary Registration District No. 5256
City Highlandville, Mo., R. 1 St. _____ Ward _____

File No. _____
Registered No. 68
St. _____ Ward _____

2. FULL NAME

M. T. Shipp

(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 ms Mrs M. T. Shipp

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 21 1878

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
51 11 2

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 _____

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

10. NAME OF FATHER Frank Shipp
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Illinois
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Henryetta Baird
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Indiana
(STATE OR COUNTRY)

14. INFORMANT Mrs M. T. Shipp
(Address) Highlandville Mo R 1

15. FILED Mch 1 1930 Loretta Leonard
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 23 1930

17. I HEREBY CERTIFY, That I attended deceased from _____
Was dead when I saw his home _____, 19____
that I last saw h_____ alive on _____, 19____, and that
death occurred, on the date stated above, at 10 o'clock a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy
Instant death (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 74 (duration) _____ yrs. _____ mos. _____ ds.

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

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) J. H. Wade _____, M. D.

2-24, 1930 (Address) Ozark 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 Highlandville cemetery DATE OF BURIAL Feb 24 1930

20. UNDERTAKER T. B. Chaffin ADDRESS Ozark 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.

