

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

Do not use this space

5775

**1. PLACE OF DEATH**

County Montgomery  
 Town Wellsburg  
 City Wellsburg

Registration District No. 595  
 Primary Registration District No. 4353

File No. 4  
 Registered No. 4  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Margaret Alice Shockley

(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 16 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED  
 HUSBAND OR (OR) WIFE OF James P. Shockley

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 20 1888

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
80 3 21

**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) same  
 (c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Portsmouth

10. NAME OF FATHER Wm. J. Shockley

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

12. MAIDEN NAME OF MOTHER Mudd

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

14. INFORMANT (Address) Albert Shockley Wellsburg Mo

15. FILED Feb 15 20 Mrs. O. D. Preville REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 10 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 11 1930 to Feb 10 1930 that I last saw him alive on Feb 10 1930 and that death occurred, on the date stated above, at 9:40 a. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Acute bronchitis.

106 B (duration) 99 W yrs. \_\_\_\_\_ mos. 6 ds.

CONTRIBUTORY (SECONDARY)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

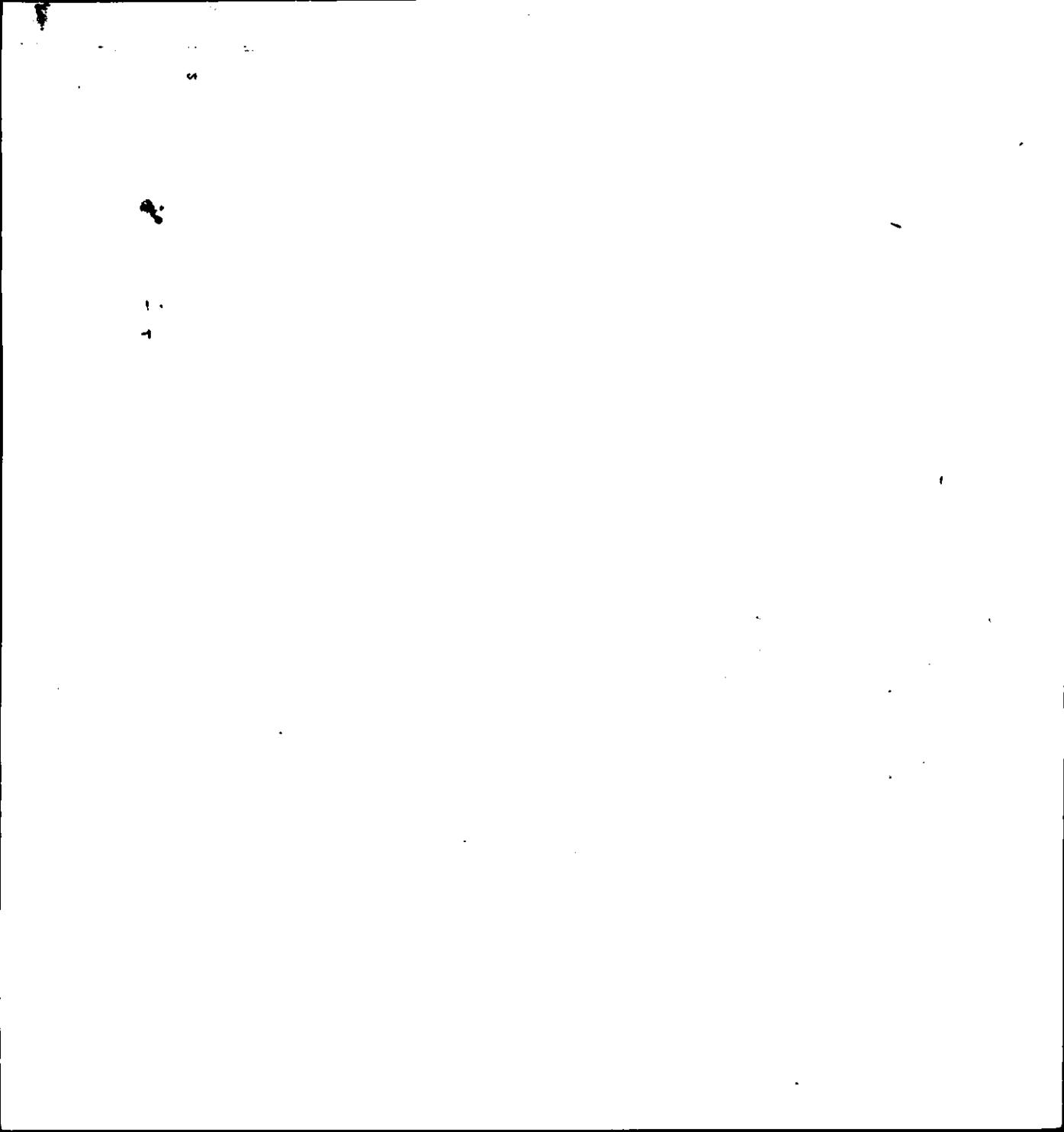
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) R. G. Stanford M. D.  
 \_\_\_\_\_ 19 \_\_\_\_\_ (Address) Wellsburg 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 Wellsburg Mo DATE OF BURIAL 2-12-30

20. UNDERTAKER O. B. Hill ADDRESS Wellsburg Mo



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CERTIFICATE OF DEATH**

ALL INFORMATION REQUESTED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County Montgomery Registration District No. 393- File No. ....  
 Township ..... Primary Registration District No. 435-3 Registered No. 4  
 City Wellsville (No. ....) St. .... Ward .....

**2. FULL NAME**

Margaret Alice Shockey

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

**PERSONAL AND STATISTICAL PARTICULARS**

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

F | W | wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 20 - 1850

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
79 3 20

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) yrs. mos. da.  
 (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 July 15, 20 Mrs O D Prewitt  
 REGISTER

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/10 1920

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

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

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

**SUPPLEMENTARY**

5-5775