

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

Do not use this space.

11723

PLACE OF DEATH

County Buchanan Registration District No. 85 File No. 434
 Township _____ Primary Registration District No. 1001 Registered No. _____
 City St. Joseph, Mo. (No. 1001) Weyer Baptist Hospital St. _____ Ward _____

2. FULL NAME Bertrude Shanks
 (a) Residence. No. _____ St. _____ Ward. Maysville mo
 (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 Female **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 Earl Shanks

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-29-1887

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>42</u>	<u>3</u>	<u>10</u>	

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

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

10. NAME OF FATHER John Sammons
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Indiana
12. MAIDEN NAME OF MOTHER Emily Sammons
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Indiana

14. INFORMANT Earl Shanks
 Address Maysville mo

15. FILED 9 **1930** John G. [Signature] REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 9 1930

17. I HEREBY CERTIFY, That I attended deceased from Mar 23 **1930**, to April 9 **1930**, that I last saw him alive on April 8 **1930**, and that death occurred, on the date stated above, at 7 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocarditis (Chronic)
127 B
93 C

(duration) 1 yrs. 6 mos. _____ ds.

CONTRIBUTORY (SECONDARY) Cholera states
 (duration) 8 yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) A. S. Simpson, M. D.

4-9, 1930 (Address) 520 Francis St

*State the DISEASE CAUSING DEATH, or in deaths from Voluntary Causes, (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oak Lawn **DATE OF BURIAL** 4/11 1930

20. UNDERTAKER W. H. [Signature] Maysville mo **ADDRESS** _____

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.

1930

