

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

Do not use this space.

25601

27

1. PLACE OF DEATH

County: Shelby
Township: Salt River
City: Shelbyville (No. _____)

Registration District No. 830
Primary Registration District No. 6091

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

2. FULL NAME

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED OR DIVORCED

HUSBAND OF Barney Bledsoe
(OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 23 - 1895

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
75 | 1 | 19 | _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Keeper
(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) Missouri

10. NAME OF FATHER

Geo. Shannon

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER

York

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) MO

PARENTS

14. INFORMANT (Address) Mr. C. A. Jordan
Shelbyville Mo.

15. FILED Aug 30 1930 Madge Good REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 12 - 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis, Hemiplegia
82 D

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 75 A

(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? clinical

(Signed) A. M. Wood, M. D.

Address Shelbyville

*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

F. C. A. Palmer July 13 1930

20. UNDERTAKER

J. B. Brothers Shelbyville 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.

AUG 26 1930

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