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

Do not use this space.

6782

1. PLACE OF DEATH
County St Clair
Township Osceola
City ..... (No. ..... St. ..... Ward)

Registration District No. 765
Primary Registration District No. 6266

File No. .....
Registered No. 7

2. FULL NAME Edmund Willes Shryer (Shryer)

(a) Residence. No. ..... St., ..... Ward ..... (If nonresident, give city or town and State)
(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.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't Know

7. AGE: Years 64; Months; Days; If LESS than 1 day, ..... hrs. or ..... min.

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) (STATE OR COUNTRY) St Clair

PARENTS
10. NAME OF FATHER J B Shryer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kent
12. MAIDEN NAME OF MOTHER Jane Nance
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Virginia

14. INFORMANT William A Shryer
(Address) Gentry Mo

15. FILED 3/10 1931 R Beeners REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-27-1931

17. I HEREBY CERTIFY, That I attended deceased from 2-23-1931, to 2-27-1931 that I last saw h. alive on 2-27-1931, and that death occurred, on the date stated above, at 11 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza and Lobar Pneumonia
(duration) ..... yrs. ..... mos. 3 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? None
(Signed) W Homer Sittan, M. D.
2-27-1931 (Address) Osceola 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 Hickory Co
DATE OF BURIAL Feb 28 1931

20. UNDERTAKER McCluney Austin
ADDRESS Osceola Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.