

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

Do not use this space.

19735

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**
(No. *Mo. Baptist Hosp.*)

File No.....
Registered No. **5723**
St..... Ward.....

2. FULL NAME

(a) Residence. No. *2148 So Lounsdale* 12. Ward. *Chicago Ill.*
(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) *Widow*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *John L. Shumate*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 13 - 1864*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>66</i>	<i>9</i>	<i>5</i>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. *Housework.*
(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) *Ireland.*

10. NAME OF FATHER *Thomas White*

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

12. MAIDEN NAME OF MOTHER *Sarah Moore*

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

14. INFORMANT.....
(Address) *Mrs Mary Rice 2148 So. Lounsdale av.*

15. FILED *19 1931* *May 19 1931*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *5 / 18 1931*

17. I HEREBY CERTIFY, That I attended deceased from *May 16th* 19*31*, to *May 18th* 19*31*, that I last saw her alive on *May 18th* 19*31* and that death occurred, on the date stated above, at *4:20 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy cerebral Admon phage

(duration) yrs..... mos. *2* ds.

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

18. WHERE WAS DISEASE CONTACTED
IF NOT AT PLACE OF DEATH *Residence*

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....

20. WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *W. F. L. ... M. D.*

, 19 (Address) *1111 W. ...*

*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 *Chicago Ill* DATE OF BURIAL *May 19 1931*

20. UNDERTAKER *Mullen and Co* ADDRESS *Delmar.*

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.

