

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

Do not use this space.

30882

1. PLACE OF DEATH

County Dade Registration District No. 237
 Township Center Primary Registration District No. 5323
 City (No.) Ward

File No. _____
 Registered No. 30

2. FULL NAME

Raleigh J. Shipley
 (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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Nancy Shipley</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 26, 1944</u>		
7. AGE YEARS <u>87</u>	MONTHS <u>2</u>	DAYS <u>13</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>ret. farmer</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>186</u>		
10. Date deceased last worked at this occupation (month and year) _____		
11. Total time (years) spent in this occupation. <u>1943</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 9, 1931
 22. I HEREBY CERTIFY, That I attended deceased from Saw him once to one day he died
 I last saw him alive on Sept 9, 1931. Death is said to have occurred on the date stated above, at 11:30 a.m.
 The principal cause of death and related causes of importance were as follows:

Heart
Traumatic Pneumonia
 Other contributory causes of importance: _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Genoa</u>
13. NAME <u>Guidance Shipley</u>
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Genoa</u>
15. MAIDEN NAME <u>Louise Mitchell</u>
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Genoa</u>
17. INFORMANT (ADDRESS) <u>Mrs Joe Stevenson</u>
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Grainfield</u> DATE <u>Sept 10</u> <u>31</u>
19. UNDERTAKER (ADDRESS) <u>J. W. Ward</u>
20. FILED <u>10-8</u> , 19 <u>31</u> <u>E. O. Ball</u> Registrar.

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify Gen. L. Weir, M. D.
 (Signed) _____ (Address) Grainfield 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.

OCT 22 1931

State

ACB of the State

BOARD OF DEATH

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Dade
Township Center
City (No.)

Registration District No. 237
Primary Registration District No. 3323

File No.
Registered No. 20
St. Ward

2. FULL NAME

Raleigh J. Shipley
(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. 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) Wid

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(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 1-1-1932 Everall

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/9 19 31

17. I HEREBY CERTIFY That I attended deceased from to , 1931, that I last saw him alive on , 1931, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Traumatic pneumonia
with protracted rib

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds. 1860
 (duration) yrs. mos. ds.

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

19

20. UNDERTAKER ADDRESS

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

Information should be carefully supplied. In plain terms, so that it may be properly classed. PHYSICIANS should state exact statement of OCCUPATION is very important.

SUPPLEMENTARY

S-3088A