

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.

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

Do not use this space.

20151

File No. 284
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County Greene
Township Springfield
City Springfield (No. R#9)

Registration District No. 318
Primary Registration District No. 5440

2. FULL NAME

(a) Residence, No. R#9 (Cherry St. Road) 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) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 14 - 1934

7. AGE YEARS 0 MONTHS 1 DAYS 6 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Infant
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. at Home
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

FATHER 13. NAME Albert F. Shelley

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER 15. MAIDEN NAME Nita Wells

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Albert F. Shelley, R#9 Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Robberson Home (Cemetery) DATE June 21 1934

19. UNDERTAKER (ADDRESS) J.W. Hingner & Co., Springfield, Mo.

20. FILED 6-21, 1934 John W. Shelley, M.D. (Address) Springfield, Mo.
Robberson Home Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-20, 1934

22. I HEREBY CERTIFY, That I attended deceased from 6-17, 1934 to 6-20, 1934

I last saw him alive on 6-19, 1934 Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Bronchial pneumonia Date of onset 6/17/34

Other contributory causes of importance: Whooping Cough

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 _____, 1934

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 _____

(Signed) C. E. Keller, M. D.

(Address) Springfield, Mo.

