

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

Do not use this space.

**1. PLACE OF DEATH**

County Saline  
Township  
City Marshall (No. St. Elizabeths Hosp)

Registration District No. 796  
Primary Registration District No. 3034

File No. 22798  
Registered No. 83  
St. 2nd Ward

**2. FULL NAME**

Mary Ann Shackelford  
(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>Female</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>Raquette Shackelford</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan 18 - 1844</u>				
7. AGE	YEARS <u>90</u>	MONTHS <u>4</u>	DAYS <u>21</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>None</u>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>✓</u>			
	10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____ <u>✓</u>			
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Cooper Co. Mo.</u>				
FATHER	13. NAME <u>Thomas Fowler</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ill.</u>			
MOTHER	15. MAIDEN NAME <u>Emily Rice</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>			
17. INFORMANT <u>Jamus Shackelford</u> (ADDRESS) <u>Marshall Mo.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Ridge Park</u> DATE <u>June 10, 1934</u>				
19. UNDERTAKER <u>T. M. Campbell</u> (ADDRESS) <u>Marshall Mo.</u>				
20. FILED <u>6/9/34</u> <u>Saline</u> Registrar				

**MEDICAL CERTIFICATE OF DEATH**

3

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 9, 1934

22. I HEREBY CERTIFY That I attended deceased from June 6, 1934 to June 9, 1934  
I saw her alive on June 9, 1934 Death is said to have occurred on the date stated above, at 1:45 m.  
The principal cause of death and related causes of importance were as follows:  
Acute intestinal obstruction Date of onset 6-6-34

Other contributory causes of importance:

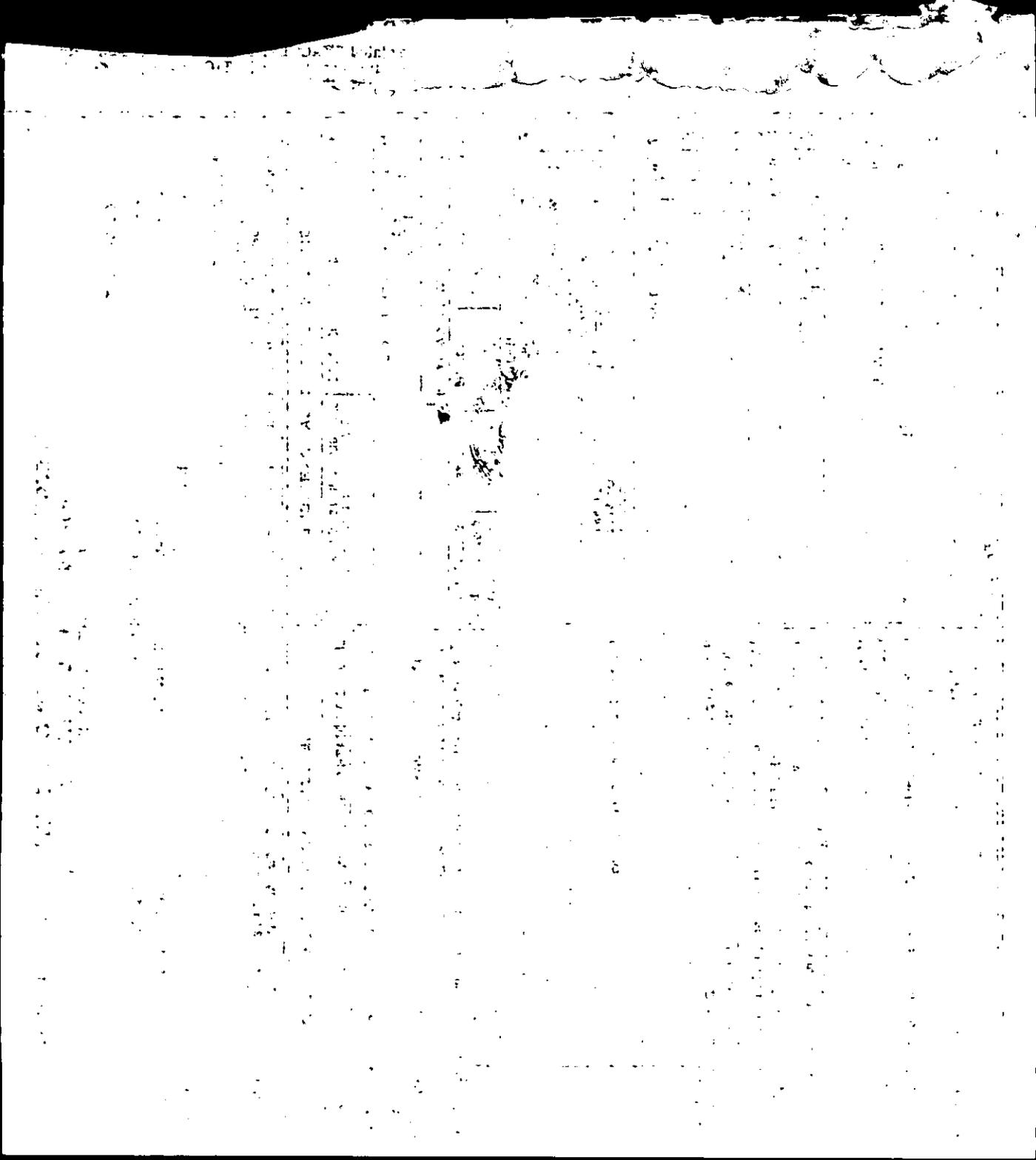
Name of operation Laparotomy Date of 6-6-34  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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 \_\_\_\_\_  
(Signed) W. H. [Signature] M. D.  
(Address) Marshall Mo.

NO. 2  
 Every item of information should be carefully checked. AGE should be stated in full. EXACT CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important.  
 JUL 14 1934  
 MARGIN RESERVE - INK - BINDING



*Saline*

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Mary Ann Shackelford  
Who died at Gibson Hosp on June 9 - 1934  
Residence: Marshall Mo St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
Sex F Color or race W Single, married, widowed or divorced: \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years 90 Months 4 Days 21

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_

Date deceased last worked at this occupation: Month \_\_\_\_\_ Year \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

Principal cause of death: ac Intestinal obstruction  
Acute gangrenous appendicitis

Other contributory causes of importance \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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 \_\_\_\_\_

Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

Name of physician \_\_\_\_\_

Address of physician \_\_\_\_\_

Signature of Registrar H. Conway

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,  
E. J. M. c Gaugh M.D.  
S.C.

Reg. Dist. No. 796

Primary Reg. Dist. No. 3036

Special Agent.

