

SEP 28 1934

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

### CERTIFICATE OF DEATH

Do not use this space.

## 1. PLACE OF DEATH

County *Gasconade*  
 Township *Brush Creek*  
 City (No. ....)

Registration District No. *306*  
 Primary Registration District No. *5-423*

File No. *28902*  
 Registered No. *21*  
 St. .... Ward

## 2. FULL NAME

(a) Residence, No. ....

(Usual place of abode)

St. ....

Ward. ....

(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 *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Widowed*  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 18- 1869*  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
*65 5 7*

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Farmer*  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Town*  
 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) *Argo Missouri*13. NAME *Walter F. Shappman*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Virginia*15. MAIDEN NAME *Virginia Conduitt*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Virginia*17. INFORMANT *Mrs Della Taylor Lee* (ADDRESS) *East Hill Missouri*18. BURIAL, CREMATION, OR REMOVAL PLACE *Oak Hill Mo* DATE *Aug 28* 193419. UNDERTAKER *W.F. Gottenstroeter* (ADDRESS) *Owensville Mo*20. FILED *9-1* 19 *34* *J.F. Ferrell* Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *8-25* 193422. I HEREBY CERTIFY, That I attended deceased from *Aug. 4-1*, 1934, to *8-25*, 1934I last saw him alive on *8-20*, 1934. Death is saidto have occurred on the date stated above, at *8 P.* m.

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

*Cerebral Hemorrhage* Date of onset*82A 99 62a*

Other contributory causes of importance:

*arterio sclerosis**general*

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? *No*

If so, specify .....

(Signed) *Joseph W Mills MD*, M. D.(Address) *Owensville Mo*

WHITE PLAINLY, WITH UNFADING INK

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.

