

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.

SEP 6

1934 MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

30199

## 1. PLACE OF DEATH

County New MadridRegistration District No. 605

File No. ....

Township ClintonPrimary Registration District No. 4359

Registered No. ....

City New Risco, Mo (No. ....) St. .... Ward)

## 2. FULL NAME

Mrs. Ella E. Shank(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 2 yrs. .... mos. .... ds. How long in U. S., if of foreign birth? yrs. .... mos. .... ds.

## 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>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>William A. Shank</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov. 26, 1911</u>		
7. AGE YEARS <u>22</u>	MONTHS <u>10</u>	DAYS <u>8</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>Housewife</u>
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <input checked="" type="checkbox"/>
	10. Date deceased last worked at this occupation (month and year) <input checked="" type="checkbox"/> 11. Total time (years) spent in this occupation <input checked="" type="checkbox"/>

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pershing Mo.13. NAME Henry Lark14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pershing Mo.15. MAIDEN NAME Lezzie Frazier16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pershing Mo.17. INFORMANT (ADDRESS) Mrs. A. Shank Tallapoosa Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE Malden Mo. DATE 8-6 193419. UNDERTAKER (ADDRESS) M. L. Lovaig Malden, Mo.20. FILED 8-5 1934 Dr. Howthorn Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 4 193422. I HEREBY CERTIFY, That I attended deceased from 7/15 1934 to 8/4 1934I last saw him alive on 8/1 1934. Death is saidto have occurred on the date stated above, at 8 a. m.

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

Bright's disease  
acute  
Date of onset 6/1/34

Other contributory causes of importance:  
Infected teeth

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

What test confirmed diagnosis? Urine Was there an autopsy? No.

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) Raydon C. Carlton, M. D.(Address) Malden

Thompson

1878

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: Mrs. Ella E. Shanks

Who died at \_\_\_\_\_ on Aug-4-1934

Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Sex ♀ Color or race Wht.  Single,  married,  widowed or  divorced: \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years 22 Months 10 Days 8

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 30

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

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

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

Principal cause of death: Bright's disease, acute  
caused from infection of teeth

Other contributory causes of importance Infection of teeth

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 Dr. Geo. W. Husted) Date filed Oct. 9, 1934

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.

Reg. Dist. No. 605 - Very truly yours, E. T. McCaugh

Primary Reg. Dist. N. 4359

