

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.

38224

NOV 15 1934

1. PLACE OF DEATH

County Shelby  
Township East Rowen  
City Shelbina (No. \_\_\_\_\_)

Registration District No. 830  
Primary Registration District No. 4503

File No. \_\_\_\_\_  
Registered No. 47  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence, No. \_\_\_\_\_ St. Mo. 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND-OR (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>July 9, 1934</u>		
7. AGE YEARS	MONTHS	DAYS
	<u>3</u>	<u>18</u>
If LESS than 1 day, _____ hrs. or _____ min.		

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

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

FATHER 13. NAME Charles W. Cullley

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

MOTHER 15. MAIDEN NAME Yera L. Young

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

17. INFORMANT (ADDRESS) Charles W. Cullley, Shelbina, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Holiday Mo. DATE Oct. 28, 34

19. UNDERTAKER (ADDRESS) E. Hayes Shelbina, Mo.

20. FILED Oct. 27, 1934 Mr. R. H. Wales, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 27, 1934

22. I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1934, to Oct. 27, 1934

I last saw her alive on Oct. 27, 1934. Death is said

to have occurred on the date stated above, at 11 a.m.

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

13 Diarrhea & Enteritis Date of onset Oct. 24

14 Septic Convulsions (Tetany)

Other contributory causes of importance:

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) James W. Hays, M. D.

(Address) Shelbina Mo.

