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

FEB 18 1935

Do not use this space.

3

1. PLACE OF DEATH
County Adair
Township Nineveh
City ..... (No. ....., ... St. ..... Ward)

Registration District No. 2
Primary Registration District No. 5002

File No. .....
Registered No. 3

2. FULL NAME Nannie Shoush

(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 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
female	white	widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF James Shoush

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 23, 1860

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	74	1	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Huntsville
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER John Henry
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Virginia
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Don't Know

14. INFORMANT Ben Stetter Stahl Mo
(Address)

15. FILED 1/17 1935 J S Gashwiler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 16 1935

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1934, to Jan 16, 1935, that I last saw her alive on Nov 18, 1934, and that death occurred, on the date stated above, at 10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Paralysis!

..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Age & angina pectoris

..... (duration) ..... yrs. 4 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH at Novinger Mo
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) J Schooling Gashwiler M. D.
1/17, 1935 (Address) Novinger Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Novinger Cemetery	1/18 1935
20. UNDERTAKER	ADDRESS
Llew Ellyn & Son	Novinger Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Adair — Registration District No. 2 — File No.
Township Nineveh — Primary Registration District No. 5002 — Registered No. 3
City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Nannie Shaush
(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 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) W

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... mins.
74	1	23	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
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)
11. Total time (years) spent in this occupation

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

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 3/29 1935 J.G. Goebwiles
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 16, 1935

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h..... alive on ....., 19..... 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:

	Date of onset
Paralyses	
asuffering	

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? .....
If so, specify .....
(Signed) ....., M. D.
(Address) .....

SUPPLEMENTARY

81a

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MAR 2 6 1935

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