

JUL 2 2 1935

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

Do not use this space.

19632

2253

1. PLACE OF DEATH

County Jackson  
Township Ray  
City N. C. Mo

Registration District No. \_\_\_\_\_  
Primary Registration District No. 11  
(No. Mercy Hospital)

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

2. FULL NAME

(a) Residence, No. 3537 Merington 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Child

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-1 1935

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

22. I HEREBY CERTIFY, That I attended deceased from 5-18 1935, to 6-1 1935  
I last saw him alive on 6-1 1935. Death is said to have occurred on the date stated above, at 9:00 P.M.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov - 1928

The principal cause of death and related causes of importance were as follows:  
Streptococci Meningitis Date of onset 5-23-35

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
7 3 -

Other contributory causes of importance:  
Left mastoiditis 5-19-35

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Child  
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) Mo

13. NAME James W. Shaw

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

15. MAIDEN NAME Virginia Barnitt

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

17. INFORMANT J. W. Shaw (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL

PLACE Green Lawn DATE June 3/35

19. UNDERTAKER Mrs. E. S. Forster (ADDRESS) 918 Broadway Ave

20. FILED 6-1 1935 Am Crowe Registrar.

Name of operation Mastoidectomy Date of 5-23-35  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Yes

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) Clyde L. Randall M. D.  
(Address) Mercy Hospital  
N. C. Mo.

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.

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