

00: 3 0 1935

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

Do not use this space.

31545

1. PLACE OF DEATH

County Schuyler
Township Pratts
City Queen City Mo. (No.)

Registration District No. 806
Primary Registration District No. 4480

File No.
Registered No.
St. Ward)

2. FULL NAME J. B. Shipman

(a) Residence, No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 17th 1857

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
77 11 20

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired Merchant

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) Indiana

13. NAME Henry Shipman

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

15. MAIDEN NAME Susan Dearduff

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not Known

17. INFORMANT Mrs J. B. Shipman (ADDRESS) Queen City Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Queen City Cem- DATE Sept. 10 35

19. UNDERTAKER Wm H. West (ADDRESS) Queen City Mo

20. FILED Sept 9 1935 J. P. Jones Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 7 1935

22. I HEREBY CERTIFY, That I attended deceased from July 17 1935 to Sept 7 1935
I last saw him alive on Sept 7 1935. Death is said to have occurred on the date stated above, at 6:30 p.m.

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

Yellow jaundice Date of onset July 1
Empyema
Cholelithiasis

Other contributory causes of importance:

remittent fever

Name of operation Date of
What test confirmed diagnosis? 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.

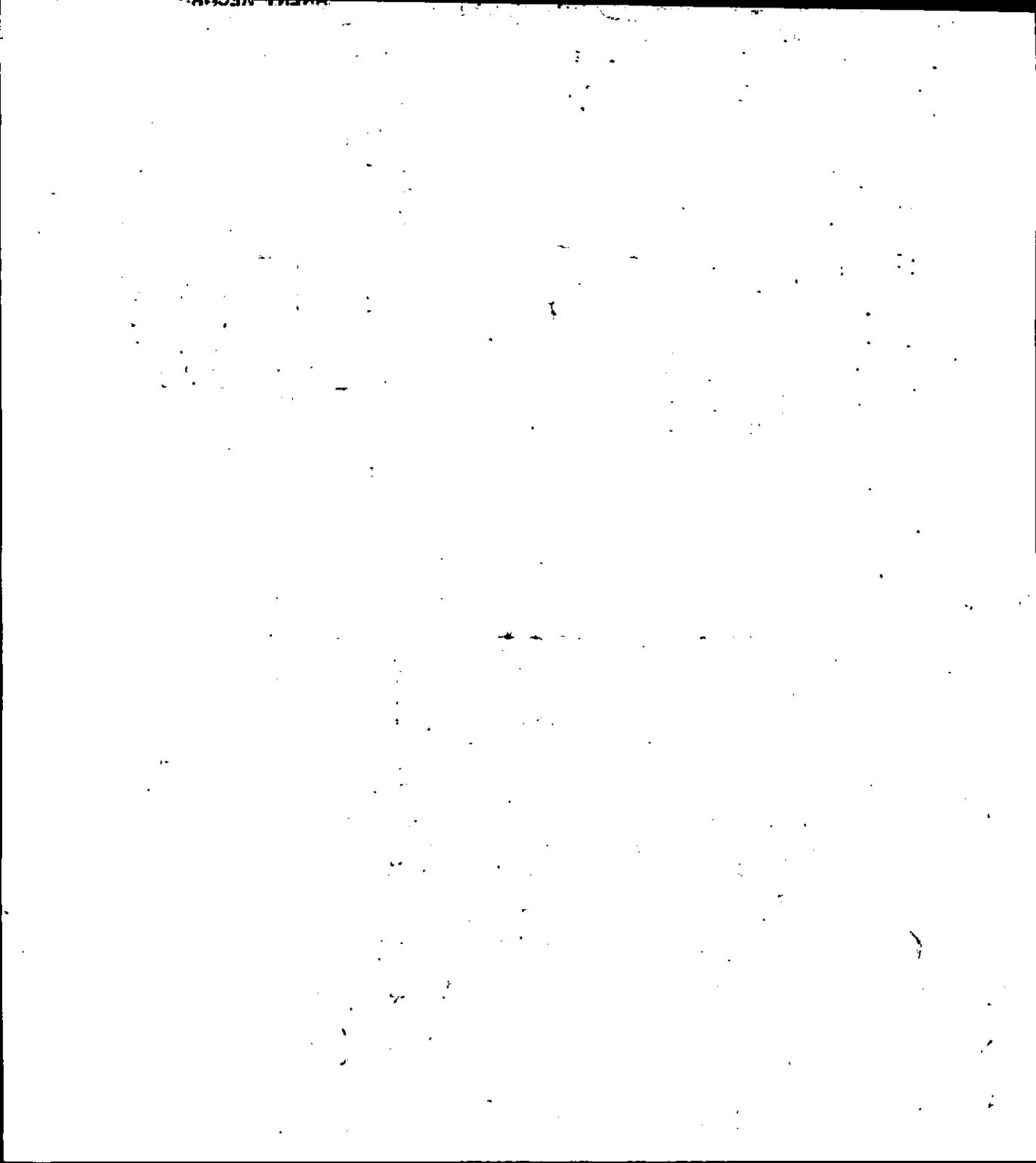
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) L. Jones M. D.
(Address) Queen City 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.

THIS IS A PERMANENT RECORD



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY Do not use this space.

1. PLACE OF DEATH

County Schuyler Registration District No. 806
Township Green City Mo. Primary Registration District No. 4485

File No.
Registered No. St. Ward)

2. FULL NAME

(a) Residence, No. J. R. Shipman 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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 min.
77 11 21

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)

13. NAME

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

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 9-9- 1935 J. J. Jones Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 17, 1935

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:

Yellow jaundice
Engorgement of the
gall bladder
no gall stones

Date of onset

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) L. Noel....., M. D.

(Address) Green City 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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