MAY 18 1937

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

Do not use this space.

1. PLACE OF DEATH
County Buchanan — Registration District No. 85 — File No. 15799
Township — Primary Registration District No. 1001 — Registered No. 504
City St Joseph (No. 405 N012 St. Ward)

2. FULL NAME Jim Shadid
(a) Residence, No. 405 N012 St., Ward. Wichita Kas
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 10 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) Divorced
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Hazel
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) about 1893
7. AGE About 44 YEARS — MONTHS — DAYS — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Cook
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Restaurant
10. Date deceased last worked at this occupation (month and year) April 26 37
11. Total time (years) spent in this occupation Life

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

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

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

17. INFORMANT (ADDRESS) Mrs Stephens Wichita Kas
18. BURIAL, CREMATION, OR REMOVAL
PLACE Good DATE April 28 1937
19. UNDERTAKER (ADDRESS) Barry-Wylie 218 So 10
20. FILED APR 28 1937 A J Nettleton Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 26, 1937

22. I HEREBY CERTIFY, That I attended deceased from April 26th 37, to ....., 19....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 5 a.m.
The principal cause of death and related causes of importance were as follows:

Cerebral Apoplexy — Date of onset 4/26/37

Other contributory causes of importance: none

Name of operation ..... Date of .....
What test confirmed diagnosis? History 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? no
If so, specify.
(Signed) B.W. Tadlock Coroner, M. D.
(Address) King Hill Bldg

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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CERTIFICATE OF DEATH

Do not use this

1. PLACE OF DEATH

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. .....

City ..... (No. ..... St. ..... Ward)

2. FULL NAME .....

(If Residence, No. ..... St., ... Ward.
(If a Place of abode) (If [illegible])

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)

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

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

7. AGE ..... YEARS ..... MONTHS ..... DAYS ..... IF LESS THAN 1 day, ... or ..... [illegible]

OCCUPATION

8. Trade, profession, or particular kind of [illegible], lawyer, bookkeeper, etc. .....

9. Industry or business in which work is done, [illegible] mill, [illegible] .....

10. [illegible] .....

11. [illegible] .....

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

MOTHER

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 ..... 19 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 19

22. I HEREBY CERTIFY, That I attended [illegible] from ..... 19 ..... to ..... 19 ..... I [illegible] alive on ..... 19 ..... [illegible] to have occurred on the date stated above [illegible] The principal cause of death and related causes of importance were as follows: (Date of [illegible])

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) .....