

OCT 27 1937

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

Do not use this space.

1. PLACE OF DEATH

County *Texas*
Township *Sherrill*
City (No. *2*)

Registration District No. *868*
Primary Registration District No. *6149*

File No. *35526*

Registered No. *19*
St. _____ Ward _____

2. FULL NAME

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

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. (If nonresident, give city or town and State)

Louisia Daw Shiph

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 27 1857*
7. AGE YEARS *79* MONTHS *10* DAYS *24* If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Turning*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Turning*
10. Date deceased last worked at this occupation (month and year) *May 1933* 11. Total time (years) spent in this occupation *20*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Richmond Mo*

13. NAME *William Shiph*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Nashville Tenn*

15. MAIDEN NAME *Martha Cyders*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ill*

17. INFORMANT *W D Nelson*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Home Creek Cem.* DATE *Sept. 22 1937*

19. UNDERTAKER (ADDRESS) *Smith Ferguson*

20. FILED *9/23*, 1937 *J. N. S. Neal* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept. 21, 1937*

22. I HEREBY CERTIFY, That I attended deceased from *Sept. 12, 1937* to *Sept. 21, 1937*
I last saw him alive on *Sept 18, 1937* Death is said to have occurred on the date stated above, at *5 1/2* m.
The principal cause of death and related causes of importance were as follows:
Chronic nephritis Date of onset *1933*

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

28. 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) *J. N. S. Neal*, M. D.

(Address) *Richmond Mo*

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.

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