

REC'D APR 12 1938

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

9990  
Do not use this space.

1. PLACE OF DEATH

(a) County Chester Registration District No. 921  
 (b) Township \_\_\_\_\_ Primary Registration District No. 4557  
 (c) City Fulton (d) Street No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred, yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Belle Shoppard 163

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF single  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 8 - 1866  
 7. AGE YEARS 72 MONTHS 6 DAYS 17 If LESS than 1 day, \_\_\_\_\_ hr. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as 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 6

FATHER 13. NAME Shoppard 0

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo 9

MOTHER 15. MAIDEN NAME See not known

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo 1

17. INFORMANT (ADDRESS) 1

18. BURIAL, CREMATION, OR REMOVAL PLACE Wright City, Mo DATE 3-27-38

19. FUNERAL DIRECTOR (ADDRESS) W. J. Hader Van Dolin

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 26 1938

22. I HEREBY CERTIFY, That I attended deceased from March 19, 1938, to March 25, 1938

I last saw h. c. alive on March 25, 1938. Death is said to have occurred on the date stated above, at 7:05 P.M.

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

Angina Pectoris  
94 a

Other contributory causes of importance: \_\_\_\_\_

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? no  
 If so, specify \_\_\_\_\_  
 (Signed) Dr. R. R. Marshall  
 (Address) Waldalia, Missouri

**STATEMENT BY LICENSED EMBALMER**

I, \_\_\_\_\_, Licensed Embalmer No. \_\_\_\_\_

hereby certify that the body recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_

L. E. \_\_\_\_\_

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do the above constitutes grounds for revocation of license.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

9990  
Do not use this space.

1. PLACE OF DEATH

(a) County Andrew Registration District No. 921  
 (b) Township \_\_\_\_\_ Primary Registration District No. 4557 Registered No. \_\_\_\_\_  
 (c) City Farber (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Belle Shaffard

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 8 - 1866  
 7. AGE YEARS 72 MONTHS 6 DAYS 17 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeping  
 9. Industry or business in which work was done, as 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  
 FATHER 13. NAME Shaffard  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_  
 MOTHER 15. MAIDEN NAME Do not know  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown  
 17. INFORMANT (ADDRESS) Mrs. Anna Stubben Farber, Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Wright City, Mo. DATE 3-27 1928  
 19. FUNERAL DIRECTOR (ADDRESS) W. S. Walter Vandalia, Mo.  
 20. FILED 48 1938 W. Rye Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 25 1938  
 22. I HEREBY CERTIFY, That I attended deceased from Mar 19 1938 to Mar 25 1938  
 I last saw her alive on Mar 25 1938. Death is said to have occurred on the date stated above, at 7:00 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Angina pectoris  
 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) R. B. Marshall E., M. D.  
 (Address) Vandalia, Mo.

BE CAREFULLY SUPPLIED. ACCIDENTAL DEATHS SHOULD BE CLASSIFIED AS OCCUPATIONAL IF THE OCCUPATION IS VERY IMPORTANT.  
 PHYSICIANS SHOULD STATE CITY, PHYSICIANS SHOULD STATE CITY, PHYSICIANS SHOULD STATE CITY.  
 REGISTERARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
 FORM-7-37

