

1938 SEP 21 1938

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

28743
Do not use this space.

1. PLACE OF DEATH

(a) County Dallas Registration District No. 242
(b) Township Grant Primary Registration District No. 5335 Registered No. _____
(c) City Buffalo (d) Street No. _____
(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

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
Frank E. Shidge 313
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct-1-1846

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
91 10 9

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Old age
9. Industry or business in which work was done, as saw mill, bank, etc. Pensioner
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) Dallas Co Mo

13. NAME George E. Shidge

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

15. MAIDEN NAME Nissa Soltman

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unk known

17. INFORMANT (ADDRESS) W. D. Shidge
Gene

18. BURIAL, CREMATION, OR REMOVAL PLACE New Hope DATE Aug. 24 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) R. B. Jones
Buffalo Mo

20. FILED Aug 26 1938 Mrs. J. R. Cox
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug-10-1938

22. I HEREBY CERTIFY That I attended deceased from _____ 19____ to _____ 19____
I last saw him alive on Aug 4 1938 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:

Paralysis of neck
151 W
Other contributory causes of importance: _____

Date of onset
2

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) P. O. Gammann, M. D.
Buffalo Mo.

RECEIVED

District Health Officer No. 7,

District File Number 7-38-46

Date Filed 9-14-38

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____, or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

28743
Do not use this space.

1. PLACE OF DEATH

(a) County Dallas Registration District No. 242
(b) Township Grant Primary Registration District No. 533.1- Registered No. _____
(c) City _____ (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 363 yrs. mos. ds. (f) How long in U.S., if of foreign birth? _____ yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
Frank ETHRIDGE

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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.
91 10 9

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) _____

MOTHER / FATHER 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. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED Aug 26 1938 R Cox Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 10 1938

22. 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:

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) C. O. Gammon, M. D.

(Address) Buffalo, Mo.

SUPPLEMENTARY

1938

S-28743