

REC'D JAN 18 1939

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

4063

Do not use this space.

1. PLACE OF DEATH

(a) County Shelby Registration District No. 831
(b) Township Black-Flores Primary Registration District No. 4504 Registered No.
(c) City Shelbyville (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)
(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 (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 2-1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
48 4 2

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Service Station
9. Industry or business in which work was done, as saw mill, bank, etc. operator
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) Shelby Co. Mo.

FATHER 13. NAME Kim Bethards

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Shelby Co. Mo.

MOTHER 15. MAIDEN NAME Anna E. Jordan

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Roads, Mich

17. INFORMANT (ADDRESS) Mrs. Rosabella Bethards
Shelbyville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE I.O.O.F. Cemetery DATE Jan. 5-1939

19. FUNERAL DIRECTOR (ADDRESS) E. P. Thompson
Shelbyville, Mo.

20. FILED Jan 4, 1939 Pearl Goe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan-4-1939

22. I HEREBY CERTIFY, That I attended deceased from April 26 1938, to Jan 4 1939
I last saw him alive on Jan 3 1939. Death is said to have occurred on the date stated above, at 11:00 P.M.

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

Pneumonia hypostatic Date of onset Jan. 3
Progressive Muscular atrophy

Other contributory causes of importance:

Progressive Muscular atrophy

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? No.

If so, specify.

(Signed) Blades Simpson D.O.

(Address) Shelbyville, Mo.

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 comply with the above constitutes grounds for revocation of license.)

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

Do not use this space.

1. PLACE OF DEATH

County Shelby Registration District No. 131
 Township Black Creek Primary Registration District No. 4504
 City Shelbyville No. _____ St. _____ Ward _____

File No. _____

Registered No. _____

2. FULL NAME Lewis Elare Bethards

(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)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 4, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from April 26, 1938 to Jan 4, 1939
 I last saw h. live alive on Jan 3, 1939. Death is said to have occurred on the date stated above, at 1:57 P.M.
 The principal cause of death and related causes of importance were as follows:

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

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

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

Pneumonia hypostatic Date of onset Jan 3

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 _____

Other contributory causes of importance:
Progressive muscular atrophy

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

FATHER 13. NAME _____

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

MOTHER 15. MAIDEN NAME _____

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED Jan 20, 1939 Pearl Goe Registrar.

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) B. Edgar Simpson 22
 (Address) Shelbyville Mo.

Exact statement of OCCUPATION is very important.

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1. PLACE OF DEATH

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No.....
City..... (No..... St..... Ward)

2. FULL NAME

(a) Residence, No..... 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)		
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.
OCCUPATION	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)				
FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
17. INFORMANT (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL				
PLACE		DATE		
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 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

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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).....

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important.