

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

11166
Do not use this space.

APR 21 1939

1. PLACE OF DEATH

(a) County Gaspar Registration District No. 411
 (b) Township Galena Primary Registration District No. 2002
 (c) City Galena (d) Street No. 2203 Conn. St. Registered No. St. John's Hosp. Galena
 (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. 802 Mineral Ave - St. Galena, KS -
 (Usual place of abode, if no street address, write county or city) (nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wife Shears
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 3-1905
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 34 0 21
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Smelter man
 9. Industry or business in which work was done, as saw mill, bank, etc. Coal & Coker
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 24 1939

22. I HEREBY CERTIFY, That I attended deceased from March 11, 1939, to March 24, 1939

I last saw him alive on March 23, 1939 Death is said to have occurred on the date stated above, at 3:15 a.m.

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

Chronic Interstitial Nephritis Date of onset 12/1

Other contributory causes of importance:

Bronchial pneumonia

Name of operation None Date of ✓

What test confirmed diagnosis? Laboratory tests where an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? no 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) [Signature] M. D.

(Address) 616 Fried Bldg. Galena

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

FATHER 13. NAME J. W. Shears

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Texas

MOTHER 15. MAIDEN NAME Low Edgman

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

17. INFORMANT (ADDRESS) Tom Low Shears Galena Kansas

18. BURIAL, CREMATION, OR REMOVAL PLACE Hill Crest Galena Kansas DATE 3-26-1939

19. FUNERAL DIRECTOR (ADDRESS) Boke Undertaking Co Galena Kansas

20. FILED 3-24-1939 [Signature] Local Registrar.

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.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

I X121004

RECEIVED

District Health Officer No. 6,

District File Number 6-29-861

Date Filed APR 12 1939

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.)