

JUN 19 1939

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

18199
Do not use this space.

1. PLACE OF DEATH

(a) County Callaway / Registration District No. 104
 (b) Township Fulton Primary Registration District No. 3008
 (c) City Fulton (d) Street No. State Hospital #1 St. Mo.
 (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. 2 mos. 1 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 245 Joe Ragland St. Shelby County (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
81 DK DK

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

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) DK

FATHER 13. NAME DK

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

MOTHER 15. MAIDEN NAME DK

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

17. INFORMANT State Hospital #1 record (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Shelby Co DATE 5/25/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Shelby Co

20. FILED May 23 1939 W. N. Crew Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 23rd 1939

22. I HEREBY CERTIFY, That I attended deceased from Mar 21st 1937, to May 23rd 1939

I last saw him alive on May 22nd 1939. Death is said to have occurred on the date stated above at 4:50 m.

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

Arteriosclerosis

97

Other contributory causes of importance:
Single Pay check
Dehydration
Arteriosclerosis

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? 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? No

If so, specify _____
 (Signed) Wm. J. Wood M. D.
 (Address) State Hospital #1 Fulton Mo

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.

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

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