

1939 AUG 16 1939

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

26315  
Do not use this space.

1. PLACE OF DEATH

(a) County Wesley Registration District No. 55  
(b) Township Edison Primary Registration District No. 4053 Registered No. 1384  
(c) City \_\_\_\_\_ (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 30 yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME JOHN WESLEY SHUTTER

(a) Residence, No. Edison Mo 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 74 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 5, 1864

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
74 9 5

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. laborer  
9. Industry or business in which work was done, as saw mill, bank, etc. Stone mill  
10. Date deceased last worked at this occupation (month and year) 1931 11. Total time (years) spent in this occupation. 11 yrs.

12. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) Sarkisburg, Indiana

13. NAME SHUTTER

14. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) IN

15. MAIDEN NAME SHUTTER

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

17. INFORMANT (ADDRESS) Paul Black, Edison, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mount Pleasant DATE July 11, 1939

19. FUNERAL DIRECTOR (NAME) R. B. Muntmeyer (ADDRESS) Edison, Mo.

20. FILED July 9, 1939 M. V. Mummola Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/10/39, 1939

22. I HEREBY CERTIFY, That I attended deceased from July 8, 1939 to July 8, 1939. I last saw him alive on July 8, 1939. Death is said to have occurred on the date stated above, at 2:40 p. m. The principal cause of death and related causes of importance were as follows:

Myocardial Failure  
auricular fibrillation  
Generalized arteriosclerosis  
arterio-sclerotic Hypertension

Other contributory causes of importance: 93 lbs

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) W. J. Walker, M. D.  
(Address) Edison, 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.

RECEIVED

District Health Officer No. 2

District File No. 839-144

Date Filed 8-14

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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

26318-  
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 53  
(b) Township \_\_\_\_\_ Primary Registration District No. 4023  
(c) City Sweden (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. (0) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 1384

2. PRINT FULL NAME

John Wesley Shutter  
(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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/10, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 1939 to \_\_\_\_\_, 1939

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

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 1939. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

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 sawyer, bookkeeper, etc. Laborer  
9. Industry or business in which work was done, as saw mill, bank, etc. Steel Mill  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

Date of onset \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Lambert Ind. (STATE OR COUNTRY) \_\_\_\_\_

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

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

15. MAIDEN NAME Unknown

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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

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

17. INFORMANT (ADDRESS) \_\_\_\_\_

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 1939

18. BURIAL, CREMATION, OR REMOVAL

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

PLACE DATE \_\_\_\_\_ 1939

Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

20. FILED July 27, 1939 M. V. Munma Local Registrar.

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) D. Hopkins, M. D.

(Address) Sweden

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.  
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-26315

1939