FILED MAR 11 1940

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

6126
Do not use this space.

1. PLACE OF DEATH
(a) County Callaway 3 Registration District No. 104
(b) Township or City Fulton Primary Registration District No. 3008 Registered No. 42
(c) Street No. State Hospital # 1 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. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Shelby MAGRUDER
(a) Residence, No. Shelbina, Mo St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) SINGLE
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 23, D.K
7. AGE YEARS 83 MONTHS D.K DAYS D.K. If LESS than 1 day, ...hrs. or ....min.

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. FARM
10. Date deceased last worked at this occupation (month and year) DK
11. Total time (years) spent in this occupation 24°

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MONROE Co Mo

FATHER
13. NAME TRAVIS MAGRUDER
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) KY

MOTHER
15. MAIDEN NAME MARGARET J. Clay
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO. O

17. INFORMANT (ADDRESS) Hosp. Records.
18. BURIAL, CREMATION, OR REMOVAL PLACE Shelbina, Mo. DATE Feb. 12 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. Hayes Shelbina, Mo.
20. FILED Feb. 12, 1940 R. N. Crews Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 10, 1940
22. I HEREBY CERTIFY, That I attended deceased from APRIL, 1939, to Feb. 10, 1940
I last saw him alive on Feb. 10, 1940 Death is said to have occurred on the date stated above, at 2:30P m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchopneumonia	
1070	

Other contributory causes of importance:
Generalized 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? .....
If so, specify .....
(Signed) Forrest Thomas, M. D.
(Address) State Hospital No. 1

(Licensed Embalmer's Statement on Reverse Side)

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

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