

JUN 18 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19683

Registration District No. 206

Primary Registration District No. 6051

Registrar's No. _____

1. PLACE OF DEATH

(a) County Schuyler, Prairie

(b) City or town Queencity MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Schuyler

(c) City or town Queencity MO (Rural)
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Raymond Roger Shirley

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex male

5. Color or race White

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 25 1940
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26
year 1940 hour 5 minute 45 A.M.

21. I hereby certify that I attended the deceased from on May 26
1940, to _____, 19____;

that I last saw him _____ alive on May 26, 19____;

and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

0 2 1 hr. min.

9. Birthplace Tracy, Mo. Iowa South Dak
(City, town, or county) (State or foreign country)

Immediate cause of death Septicemia due to cellulitis of both right + left great toe

Due to Ingrowth toenails of both great toes

Due to _____

Other conditions (Include pregnancy within 3 months of death) 3/6

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER { 12. Name Ray R. Shirley

13. Birthplace Queencity MO
(City, town, or county) (State or foreign country)

14. Maiden name Christine Owens

15. Birthplace Tracy Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Ray R. Shirley

(b) Address Queen City Mo

17. (a) Buried (b) Date thereof 5 27-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Queencity Cemetery

18. (a) Signature of funeral director Wm G West

(b) Address Queencity MO

19. (a) May 27-1940 (b) _____
(Date received local registrar) (Registrar's signature)

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature W. W. Jhr D O (M. D. or other) 3

Address Queen City, MO Date signed May 28/1940

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

18

RECEIVED

District Health Officer No. 10

District File Number 6-40-1252

Date Filed JUN 12 1940

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 No
Embalming, Registered Apprentice No. _____
working under my personal supervision.

Signed Wm G West

Licensed Embalmer No. 2882

P. O. Address Queer City Mo

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19683

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 806

Primary Registration District No. 6057

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
MOTHER FATHER

PLACE OF DEATH:
(a) County Schuyler
(b) City or town Prairie
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Raymond Roger Shirley
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.
2 1 _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) May 27 - 1940 (b) J. J. Jones - Oliver Jones - Dep.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town Rural Queen City, Mo (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH Month May day 26 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) Means of injury _____

23. Signature W. V. Lebr (M. D. or other) _____
Address Queen City Date signed _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

