

SEP 16 1940  
Registration District No. 124

Primary Registration District No. 5177

Registrar's No. 31

## 1. PLACE OF DEATH:

- (a) County Cape Girardeau (Mo.)  
 (b) City or town Rural (Rural)  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location) 2

- (d) Length of stay: In hospital or institution \_\_\_\_\_
- 
- (Specify whether

In this community  
years, months or days) 11 1/23. (a) PRINT FULL NAME Bezerial Shirkard3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Ladie Parkinson Shirkard 6. (c) Age of husband or wife if alive 75 years7. Birth date of deceased Jan 18 1863  
(Month) (Day) (Year)8. AGE: Years 87 Months 6 Days 29 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Cape Girardeau County, Mo.  
(City, town, or county) (State or foreign country)10. Usual occupation farmer

11. Industry or business \_\_\_\_\_

12. Name David H. Shirkard13. Birthplace Cape Girardeau County, Mo.  
(City, town, or county) (State or foreign country)14. Maiden name Mary Ester15. Birthplace Cape Girardeau County, Mo.  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature D. W. Shirkard(b) Address Burfordville Mo17. (a) Rural (b) Date thereof Aug 17 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Marley Mo18. (a) Signature of funeral director Marley - Wilson - Statler(b) Address Marley Mo19. (a) 8-16-40 (b) D. G. Shirkard  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Cape Girardeau  
 (c) City or town Rural Burfordville 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.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 16  
year 1940 hour 11 minute 30 A. M.21. I hereby certify that I attended the deceased from June 30  
1940, to Aug 16, 1940  
that I last saw him alive on Aug 9, 1940  
and that death occurred on the date and hour stated above.Immediate cause of death Mys-Pneumonia Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Acute Nephritis  
(include pregnancy within 3 months of death)Major findings: ✓  
Of operations \_\_\_\_\_Of autopsy NO22. 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?  
100 (Specify type of place) \_\_\_\_\_While at work? ✓ (e) Means of injury ✓23. Signature D. G. Shirkard (M. D. or other) \_\_\_\_\_Address Burfordville Mo Date signed 8-16-40

42c

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**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 28189

Registration District No. 124

Primary Registration District No. 5177

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Cape Girardeau

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

(c) Name of hospital or institution: \_\_\_\_\_  
(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 \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (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 Hezekiah Shinkar

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 m

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

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

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

87 6 29 \_\_\_\_\_ hr \_\_\_\_\_ 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)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month aug day 10 year 1970 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 myocardial infarction

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions acute nephritis  
(include pregnancy within 3 months of death)  
Not known

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 J. Jackson (M. D. or other) \_\_\_\_\_

Address Keokuk Mo Date signed \_\_\_\_\_

SUPPLEMENTAL

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

ROWENA MOORE

