

STANDARD CERTIFICATE OF DEATH

State File No. **29847**

Registration District No. **1077**

Primary Registration District No. **1081**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Shannon**
 (b) City or town **Shannon**
 (c) Name of hospital or institution: **Rural**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **2**
 (Specify whether years, months or days) **111**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Shannon**
 (c) City or town **State Mo**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **Rural**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.?

8. (a) PRINT FULL NAME

Mary Jane Shackley

3. (b) If veteran, name war **X**

8. (c) Social Security No. **X**

4. Sex **F** 5. Color or race **A** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife **A. J. Shackley** 6. (c) Age of husband or wife if alive **13** years

7. Birth date of deceased **7 13 1852**
 (Month) (Day) (Year)

8. AGE: Years **84** Months **1** Days **1** If less than one day hr. min.

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

10. Usual occupation **Anty**

MOTHER FATHER
 11. Industry or business
 12. Name **M. J. Shump**
 13. Birthplace **Ripley Co. Mo.**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Rogers**
 15. Birthplace **Mo.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Roy C. Wallace**
 (b) Address **State Mo.**

17. (a) **Removal** (b) Date thereof **Aug 16 1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Liberty (Belle)**

18. (a) Signature of funeral director **W. B. ...**
 (b) Address **Yellow Springs Mo. 7111**

19. (a) **8-14-40** (b) **Frank Hyde M.D.**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **14**
 year **1940** hour **4** minute **P** 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 **Apoplexy**

Due to _____

Due to **Stroke**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 **Frank Hyde** (M. D. or other) **1**
 Address **Lawrence** Date signed **8-14-40**

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

X21492

RECEIVED

District Health Officer No. 5,

District File Number... 920956

Date Filed _____

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 J. O. Burns

Licensed Embalmer No. 3379

P. O. Address Shilow Springs, Md

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **29847**

Registration District No. **10.77**

Primary Registration District No. **6081**

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County **Shannon**

(b) City or town **Gasper**
(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 years, months or days)

In this community _____

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 **Mary Jane Hoekley**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH Month **Aug** day **14**
year _____ 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.

4. Sex **F**

5. Color or race **w**

6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **July**
(Month) (Day) (Year)

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years **84** Months **1** Days **1**
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **8-5-40** (b) **Frank Hede M.D.**
(Date received local registrar) (Registrar's signature)

Major findings:
Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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? _____
(Specify type of place)

While at work _____ (e) Means of injury _____

23. Signature **Frank Hede** (M. D. or other) _____

Address **Commerce Mo** Date signed _____

SUPPLEMENTARY

