

FILED SEP 18 1941

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

1. PLACE OF DEATH

County Vernon  
Township Henry  
City Stotsbury (No. ....)

Registration District No. 879  
Primary Registration District No. 61.67

File No. 29626  
Registered No. ....  
St. .... Ward)

2. FULL NAME

Augustus B. Shackelford

(a) Residence No. Stotesbury Mo. St. Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. .... mos. .... ds. How long in U.S., if of foreign birth? yrs. .... mos. .... ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

Clara Shackelford

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 10 - 1866

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
74 | 10 | 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) Own farm  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Pa.

10. NAME OF FATHER

Samuel B. Shackelford

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) None

12. MAIDEN NAME OF MOTHER

Rebecca Ryan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Don't know

14.

INFORMANT Clara Shackelford  
(Address) Stotesbury Missouri

15.

FILED Sept 3, 1941 Minnie B. Denton  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 3<sup>rd</sup> 1941

17. I HEREBY CERTIFY That I attended deceased from Aug 30<sup>th</sup> 1941 to Sept 3<sup>rd</sup> 1941 that I last saw him alive on Sept 2<sup>nd</sup> 1941, and that death occurred, on the date stated above, at 3:15 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral Haemorrhage

CONTRIBUTORY (SECONDARY)

Arteriosclerosis  
(duration) 4 yrs. .... mos. .... ds.  
2 yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Clara B. Allen, M. D.

, 19 (Address) Stotesbury, Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS and NATURE of INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Clara Shackelford Sept 16 - 1941  
20. UNDERTAKER O. W. Cheney ADDRESS 14 Scott

N. E. - 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.

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

RECEIVED  
District Health Officer No. 7,  
District File Number \_\_\_\_\_  
File No. \_\_\_\_\_  
Date filed \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

1. PLACE OF DEATH

County \_\_\_\_\_  
Township \_\_\_\_\_  
City \_\_\_\_\_ (No. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. \_\_\_\_\_  
Primary Registration District No. \_\_\_\_\_

2. FULL NAME

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

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

PARENTS  
10. NAME OF FATHER \_\_\_\_\_  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_  
12. MAIDEN NAME OF MOTHER \_\_\_\_\_  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT (Address) \_\_\_\_\_

15. FILED \_\_\_\_\_ 19 \_\_\_\_\_ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) \_\_\_\_\_ 19 \_\_\_\_\_  
17. \_\_\_\_\_

I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19 \_\_\_\_\_, to \_\_\_\_\_, 19 \_\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

\_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH? \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_ (Signed) \_\_\_\_\_, M. D. \_\_\_\_\_, 19 \_\_\_\_\_ (Address) \_\_\_\_\_

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 19 \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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.