

No. 2
1-3-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JUL 30 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26356

Registration District No. 336

Primary Registration District No. 6206

Registrar's No. 24

1. PLACE OF DEATH: Tellico, Mo
 (a) County Raymond-Earl-Shanks
 (b) City or town Raymondville Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Lockman Ins
 (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: 107
 (a) State Missouri (b) County Jackson
 (c) City or town Raymondville Rural
 (If outside city or town limit, write "RURAE")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME RAYMONT EARL SHANKS
 (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Male 5. Color or race Whit 6. (a) Single, widowed, married 1 divorced Married
 6. Name of husband or wife Blanche Lewis 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Dec 31 1882
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 6 18 hr. min.

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

10. Usual occupation mechanic

11. Industry or business Garage

12. Name Samuel Shanks
 13. Birthplace unknown 9
 (City, town, or county) (State or foreign country)

14. Maiden name Nancy Griffin
 15. Birthplace unknown 9
 (City, town, or county) (State or foreign country)

16. (a) Informant Blanche Shanks wife
 (b) Address Raymondville Mo
 17. (a) burial (b) Date thereof June 20 43
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Allen Cemetery

18. (a) Signature of funeral director Russell Barber
 (b) Address Mo Grove Mo
 19. (a) 6-26-43 (b) Mrs. Ella Duff
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17
 year 1943 hour 3:00 minute _____ A. M.
 21. I hereby certify that I attended the deceased from July 10
 _____, 1944, to June 17, 1943;
 that I last saw him alive on June 16, 1943,
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of R. Lung
 Duration 1 year

Due to _____
 Due to _____

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?
 _____ (Specify type of place) (e) Means of injury sd
 23. Signature N. R. Rosy (M. D. or other) D.O.
 Address Houston, Mo. Date signed 6-18-43

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

MOTHER FATHER

AUG 1 1948

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

Frank W. Barber

Licensed Embalmer No.

3048

P. O. Address

127 Grove St

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.

Registration District No. 356 Primary Registration District No. 6206

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

1. PLACE OF DEATH: Texas
 (a) County Rural-Jackson
 (b) City or town 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) (Specify whether

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) Citizen of foreign country? (Yes or No)
 If yes, name country

3. (a) PRINT FULL NAME Raymond Earl Shank
 3. (b) If veteran, name war. 3. (c) Social Security No.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month January year 1943 hour 7 minute M.
 21. I hereby certify that I attended the deceased from 1943 to 1943 that I last saw him alive on 1943 and that death occurred on the date and hour stated above. Immediate cause of death

5. Color or race M W
 6. (a) Single, widowed, married, divorced M
 6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
 7. Birth date of deceased Dec 31 (Month) (Day) (Year)

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

8. AGE: Years 60 Months 6 Days 6 (If less than one day min.)
 9. Birthplace Iowa (City, town, or county) (State or foreign country)

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

10. Usual occupation
 11. Industry or business
 12. Name
 13. Birthplace (City, town, or county) (State or foreign country)
 14. Maiden name (City, town, or county) (State or foreign country)
 15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address
 17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
 (c) Place: burial or cremation
 18. (a) Signature of funeral director (b) Address
 19. (a) (Date received local registrar) (b) (Registrar's signature)

23. Signature (M. D. or other)
 Address Date signed

SUPPLEMENTARY

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

S-26356