

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35504

State File No. _____

Registration District No. 276

Primary Registration District No. 547

Registrar's No. _____

1. PLACE OF DEATH:

(a) County PHELPS
(b) City or town ST. JAMES, Mo. "Rural"
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. JAMES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: in hospital or institution 4 DAYS
(Specify whether
In this community 4 DAYS 0
years, months or days)

3. (a) PRINT FULL NAME HATTIE SHOCKLEY

3. (b) If veteran, name war -
3. (c) Social Security No. -

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife S.L. SHOCKLEY
6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased JULY 31 1899
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 2 19 - hr. - min.

9. Birthplace OSAGE COUNTY MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business _____

12. Name TILMAN PHELPS

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

14. Maiden name KATHERINE BRANSON

15. Birthplace OSAGE COUNTY MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant S.L. Shockley

(b) Address Bland, Mo. R. 3.

17. (a) BURIAL (b) Date thereof 10 23 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BLAND UNION CEM.

18. (a) Signature of funeral director Michael H. N. Winter
(b) Address Overtonville Mo.

19. (a) 10-21-1943 (b) Charles Dickson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County OSAGE 76
(c) City or town BLAND ROUTE 3.0
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 20
year 1943 hour 1 minute 45 P.M.

21. I hereby certify that I attended the deceased from Sept 1 -
1943 to Oct 20 1943
that I last saw her alive on Oct 20 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Older Pneumonia

Due to Infected sore throat

Due to Overworked system for recreation of pleasure

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

Major findings: Of operation Chronic bronchitis
Older bacterial pneumonia
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? No (Specify type of place) (e) Means of injury fall

23. Signature E. A. Smith M.D. (M. D. or other)
Address St. James Hospital Bland Mo. Date signed 10/23/43

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

MOTHER FATHER

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

1097

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 Me

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

Signed Milford H. White

Licensed Embalmer No. 3838

P. O. Address Owensville Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov. 1943

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Whelpa
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. James Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 da. (Specify whether years, months or days)

In this community 4 da. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Hattie Shockley

3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex 7 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 57 years

7. Birth date of deceased: July 31 1886
(Month) (Day) (Year)

8. AGE: Years 54 Months 2 Days _____ If less than one day, _____ 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 _____
(Burial, cremation, or removal) (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)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 2
year 1943 hour _____ minute _____ M.

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

Immediate cause of death: Other Pneumonia
Inhalation of ether &
anesthetic given for
Due to resection of rectum,
Rectopexy, & vaginectomy
Due to infection from resection of
Bladder with prostate of bladder
Other conditions: severe blood loss
(include pregnancy within 3 months of death)

Major findings: Ch. Inflammation of
Of operations: _____
lower bowel, vaginal &
Of autopsy: rectum.
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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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

ditw v

35504

JAN 3 1944