No. 2
2-43
17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 5

Registration District No. 360

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3076

State File No. 19375

Registrar's No. 65

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

1. PLACE OF DEATH:
(a) County: Vernon
(b) City or town: Nevada (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Nevada City Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 3 days (Specify whether years, months or days) In this community: 0

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Vernon
(c) City or town: Walker (If outside city or town limits, write "RURAL") 107
(d) Street No.: Route 1 (If rural, give location) 1
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country: 0

3. (a) PRINT FULL NAME: Joseph Harvey Shockley
3. (b) If veteran, name war: No
(c) Social Security No.: No

4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Feb. (Month) 6 (Day) 1944 (Year)

8. AGE: Years | Months: 3 | Days: 10 | If less than one day: hr. min.

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

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Joseph Glen Shockley
13. Birthplace: Conway (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name: Mary Ellen Martin
15. Birthplace: Oak City (City, town, or county) Texas (State or foreign country)

16. (a) Informant: Mary Ellen Shockley
(b) Address: Walker Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 5-16-44 (Month) (Day) (Year)
(c) Place: burial or cremation: Walker, Mo.

18. (a) Signature of funeral director: March Eichinger
(b) Address: Nevada, Mo.

19. (a) 5-16-44 (Date received local registrar) (b) Hazel B. Beirich (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 16 year: 1944 hour: 4:30 minute: A. M.

21. I hereby certify that I attended the deceased from 5-13, 1944, to 5-16, 1944, that I last saw him alive on 5-15, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death: Unknown. Possibly bulbar type of anterior poliomyelitis — Duration: 5 days
Due to: or encephalitis as a complication
Due to: of pertussis.

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

Major findings:
Of operations: 36
Of autopsy: 0

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: C. Brooks Davis (M. D. or other)
Address: Nevada, Mo. Date signed: 5-16-44

1331

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 5-44-665
Date Filed 6-2-44

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 O. E. Huffman

Licensed Embalmer No. 2030

P. O. Address Fort Scott Kan

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

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

No. 2B
--5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 760 Primary Registration District No. 3076 Registrar's No. 65

1. PLACE OF DEATH:
(a) County Vernon
(b) City or town Nevada
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Nevada City Hospital
(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) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Joseph H. Shockley
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 S
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased Feb 6 1944
(Month) (Day) (Year)
8. AGE: Years ..... Months 3 Days ..... If less than one day: hr. ..... min.
9. Birthplace [redacted] (City, town, or county) Missouri (State or foreign country)
10. Usual occupation .....
11. Industry or business .....
FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)
MOTHER
14. Maiden name .....
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) Hazel B. Beurck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 16 year 1944 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	Duration
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)
While at work? ..... (e) Means of injury .....
23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

19375