

FILED OCT 29 1945 **STANDARD CERTIFICATE OF DEATH**

Registration District No. 1210

Primary Registration District No. 5460

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Barabway Clay Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 8 Months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39
(c) City or town Barabway Clay Township 0
(If outside city or town limits, write "RURAL")
(d) Street No. Route 3 Springfield, Mo. 0
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James Lee Shockley

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

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec. 14 1944
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 8 13 hr. min.

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Earl Eugene Shockley

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

14. Maiden name Helen Louise Taylor
(City, town, or county) (State or foreign country)

15. Birthplace Springfield Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Earl E. Shockley

(b) Address Route # 3 Springfield, Mo.

17. (a) Burial (b) Date thereof 8/31/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galloway

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) August 30 45 (b) Mrs. Frank Smith
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 27
year 1945 hour 7 minute 30a. M.

21. I hereby certify that I attended the deceased from 1-4-1945 to 8-27-45
that I last saw him alive on 8-14-45 and that death occurred on the date and hour stated above.

Immediate cause of death Congenital malformation of heart
Due to _____

Due to _____
Other conditions Premature birth
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy 157

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) (Specify type of place)
Means of injury? _____
23. Signature Archie Busick (M. D. or other)
Address Springfield Mo Date signed 8-28-45

Duration

life

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

Greene County Health Office,

County File Number... 45-10-75

Date Filed 10-26-45

OCT 31 1945

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 L. L. Doolin

Licensed Embalmer No. 3177

P. O. Address Springfield, Mo.

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, fact should be so stated above.