

S. No. 2  
I-1/47  
5-17-39

28439

FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registered District No. \_\_\_\_\_  
Fixed Date 29 1947

Primary Registration District No. 4362

Registrar's No. 38

1. PLACE OF DEATH:

(a) County: Scott

(b) City or town: New Madrid  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: none  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 68 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Scott

(c) City or town: Marshall  
(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: JAMES MILES SHIRKEY

3. (b) If veteran, name war: /

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 28  
year 1947 hour 11 minute 15 P M.

4. Sex: SMO 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: \_\_\_\_\_ years

7. Birth date of deceased: 6 11 1868  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 15, 1947, to Apr May 28, 1947, that I last saw him alive on April 16, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death: apoplexy

8. AGE: Years 68 Months 10 Days 22 If less than one day \_\_\_\_\_ br. 1 min \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

10. Usual occupation: Thinning

Other conditions (Include in parenthesis within 3 months of death): apoplexy

11. Industry or business \_\_\_\_\_

12. Name: unknown

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

14. Maiden name: unknown

15. Birthplace: unknown (City, town, or county) (State or foreign country)

Major findings: apoplexy

Of operations: 43A

Of autopsy: \_\_\_\_\_

16. (a) Informant: Chester Shirkey

(b) Address: Marshall Mo

17. (a) Burial, cremation, or removal: Burial

(b) Date thereof: 5/28/47 (Month) (Day) (Year)

(c) Place: burial or cremation: Cape Girardeau

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)

18. (a) Signature of funeral director: James M. Sheeter

(b) Address: Marshall Mo

19. (a) 5/28-47 (Date received local registrar)

(b) Thomas M. Sheeter (Registrar's signature) 220

23. Signature: apoplexy (M. D. or other) \_\_\_\_\_

Address: Marshall Mo Date signed: \_\_\_\_\_

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

MOTHER FATHER

RECEIVED

District Health Office No.

District File Number 847-112

Date Filed 8-29-47

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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 SEP 4 1947

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

Signed John Allerton

Licensed Embalmer No. 2941

P. O. Address Septon Ave

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.