30 1928

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

30964

File No.
Registered No. 61

1. PLACE OF DEATH
County Lawrence
Township Aurora
City Aurora (No. , St. Ward)

Registration District No. 467
Primary Registration District No. 4280

2. FULL NAME Shelton W. Easley
(a) Residence. No. St., Ward. Marionville Mo
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF X

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 22 1870

7. AGE: Years 56 | Months 7 | Days 12 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Contractor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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127
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9. BIRTHPLACE (CITY OR TOWN) Polk Co
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Wharham Easley
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Polk Co
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Mary Jane Hopkins
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Polk Co
(STATE OR COUNTRY) Mo

14. INFORMANT Mary Jane Easley
(Address) Marionville Mo

15. FILED 9/5, 1928 Rue Smart
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 4 1928

17. I HEREBY CERTIFY, That I attended deceased from July 3, 1928, to Sept 4, 1928, that I last saw him alive on Sept 4, 1928, and that death occurred, on the date stated above, at 4:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Exhaustion from Hiccough
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY) Gallbladder infection
(duration) yrs. 5 mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? yes DATE OF July 3, 28
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) R. E. Swing, M. D
, 19 (Address) Aurora

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Maple Park Cem
DATE OF BURIAL: Sept 6 1928

20. UNDERTAKER: Berg Funeral Home
ADDRESS: Aurora Mo

N. B.—d be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE O m, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Lawrence — Registration District No. 467 — File No. .....

Township ..... — Primary Registration District No. 4280 — Registered No. 61

City Aurora (No. ..... St. ..... Ward)

2. FULL NAME Shelton W. Easley

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	S

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 22 - 1870

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	58	4	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED ....., 19..... [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 4 1928

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Exhaustion from hiccough
Gal Stones obstructing Duct
Gal bladder filled with Pus
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Gall bladder infection
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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Every item of information sh... N. B.—EVERY DEATH ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-30964