

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

Do not use this space.

File No. **32925**
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County Barton
Township Newport
City North of Golden City

Registration District No. 1008
Primary Registration District No. 5057

2. FULL NAME

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

Myrtle D. Shaw

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 21, 1902

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
26 10 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife.
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

10. NAME OF FATHER W. B. Daniel

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

12. MAIDEN NAME OF MOTHER Gertie E. Manis

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

14. INFORMANT W. B. Daniels
(Address) Golden City Mo. R.F.D.

15. FILED 10-29-29 E. O. Ball
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 4 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar 10 - 1929 to Apr 29 - 1929, and that I last saw h. or alive on Apr 29 - 1929, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
23A
at least three years
(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED 31

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Dr. Parks _____ M. D.

Oct 10, 1929 (Address) Golden City Mo

*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 Greenfield Cemetery DATE OF BURIAL Oct. 13 1929

20. UNDERTAKER J. W. Ward ADDRESS Greenfield Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

M. B.—Every item of information 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.

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REC A
STATE PHYSICIAN
REGISTRATION

USE OF D
H-1-1-1

6/1/19

32925