

N. 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.

Call 741
154 my comm. plate
1939

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

Dr. DeLoe may
45146
Do not use this space.

1. PLACE OF DEATH
 (a) County GREENE Registration District No. 318
 (b) Township _____ Primary Registration District No. 2001
 (c) City SPRINGFIELD (d) Street No. 445 E. Elm Registered No. 1019
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Isabelle M. Shultz
 (a) Residence, No. 445 E. Elm St. 5 (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elias Shultz (Dec)
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 9, 1843
 7. AGE YEARS 95 MONTHS 5 DAYS 21 If LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. Home
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stack Bridge, New York
 13. NAME Lepta Jackson
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York
 15. MAIDEN NAME Mary Demison
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York
 17. INFORMANT (ADDRESS) Isabelle Shultz, Springfield, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Seymour Mo. DATE Sept. 1, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Blind Gabeys, Springfield, Mo.
 20. FILED Dec 30, 1938 Chas. A. George, Jr. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 30, 1938
 22. I HEREBY CERTIFY, That I attended deceased from Dec 27, 1938 to Dec 30, 1938
 I last saw h. or alive on Dec 30, 1938 Death is said to have occurred on the date stated above, at 5:10 P.M.
 The principal cause of death and related causes of importance were as follows:
Acute purulent Bronchitis Date of onset 12/16/38
 Other contributory causes of importance: Senility
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____ (Signed) Ray DeLoe M. D.
 (Address) Springfield, Mo.

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.