

DEC'D MAR 15 1939

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

6650  
Do not use this space.

1. PLACE OF DEATH *2*  
(a) County *Henry* Registration District No. *347*  
(b) Township *Field Creek* Primary Registration District No. *5490*  
(c) or City..... (d) Street No.....  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(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 *Thomas Shirley*  
(a) Residence, No. *County Home* St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *M* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *2-8* 19*39*

22. I HEREBY CERTIFY, That I attended deceased from *2-6-* 19*39* to *2-8* 19*39*.  
I last saw him alive on *2-8* 19*39*. Death is said

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
*67* *unknown*

The principal cause of death and related causes of importance were as follows:

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Co. Home*  
9. Industry or business in which work was done, as saw mill, bank, etc. *Farm labor*  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

*Double Bronchial Pneuma* Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Calhoun Mo*

Other contributory causes of importance: *1939 W Epilepsy*

FATHER  
13. NAME *William Shirley*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *unknown*

MOTHER  
15. MAIDEN NAME *unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *unknown*

17. INFORMANT (ADDRESS) *Mrs Wm Collins*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Englewood* DATE *July 9* 19*39*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Garland Funeral Home*  
*Leighton Mrs*

20. FILED *2-13* 19*39* *J R Hampton* Local Registrar

Name of operation..... Date of.....  
What test confirmed diagnosis? *clinical* 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?....., specify

(Signed) *J R Hampton*, M. D.  
(Address) *Clinton Mo*

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.

RECEIVED  
District Health Officer No. \_\_\_\_\_  
District File Number 7-35-32  
Date Filed 3-3-29

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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.....

....., 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 do with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**