

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

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 12 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

6701

Registrar's No.

190

Registration District No. 318

Primary Registration District No. 2439

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town SPRINGFIELD MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: FARMERS PRIVATE SANITARIUM 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 31 DAYS (Specify whether
In this community DONT KNOW
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County GREENE
SPRINGFIELD MO
(c) City or town 0 (If outside city or town limits, write "RURAL")
(d) Street No. RFD No. 4 (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Mrs. Castilla Shalley 1.00

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife JOH N SHALLEY 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 1 (Month) 1 (Day) 1864 (Year)

8. AGE: Years 76 Months 1 Days 24 If less than one day hr. _____ min. _____

9. Birthplace DONT KNOW (City, town, or county) (State or foreign country) 9

10. Usual occupation DONT KNOW 7

11. Industry or business DONT KNOW 7

12. Name DONT KNOW 7

18. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name DONT KNOW

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

16. (a) Informant's own signature A. M. Shalley

(b) Address RED NO 2 COYLE OKLA

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 2/29/40 (Month) (Day) (Year)

(c) Place: burial or cremation COYLE, OKLA.

18. (a) Signature of funeral director Paul P. Smith

(b) Address 739 N main ave

19. (a) 2/27/40 (Date received local registrar) (b) Chas. R. Hoop M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 25 year 1940 hour 6:30 minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan. 20, 1940, 19____ to 2, 25, 40, 19____; that I last saw him alive on er 2, 28, 40, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cancer-face and eyes Duration Don't know

Primary cheek

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature D. M. Muck (M. Doctor) _____

Address Springfield, Mo. Date signed 2, 26, 40

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

Fred W. [unclear]

Licensed Embalmer No. *2886*

P. O. Address *Springfield*

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.

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