

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

504-10-22-36  
I 20314

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.

FILED MAR 10 1940

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

Do not use this space.

1. PLACE OF DEATH  
 County Philly Registration District No. 695  
 Township Philly Primary Registration District No. 5-0-2  
 City (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 2. FULL NAME Henry Roger Speller  
 (a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

File No. 7813

Registered No. \_\_\_\_\_

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Olivia Speller  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 20, 1873  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 66 12 14 16  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation 1  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pennsylvania  
 13. NAME William C. Speller 9  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pennsylvania  
 15. MAIDEN NAME Mrs. M. McKenzie  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)  
 17. INFORMANT (ADDRESS) Arthur J. Speller  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Parkville DATE March 12, 1940  
 19. UNDERTAKER (ADDRESS) Noland  
 20. FILED 8-19 1940 S. P. Ford Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 8, 1940  
 22. I HEREBY CERTIFY, That I attended deceased from Mar 6, 1940, to Mar 8, 1940  
 I last saw him alive on March 9, 1940 Death is said to have occurred on the date stated above, at 11 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Broncho-Pneumonia Mar 6  
 Other contributory causes of importance: Flu Mar 1  
 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? Yes  
 If so, specify \_\_\_\_\_  
 (Signed) Dr. J. Underwood M. D.  
 (Address) Parkville, Mo

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RECEIVED FILED STATE OFFICE  
INDEX CARD RETURNED TO DISTRICT

DATE 3-21-40

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **7813**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **695-**

Primary Registration District No. **5922**

Registrar's No. ....

1. PLACE OF DEATH

(a) County **Platteau**  
(b) City or town **Pettis**  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME **Henry Roger Sheller**

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

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

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

8. AGE: Years **66** Months **7** Days **16** If less than one day hr. min.

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

10. Usual occupation **Librarian**

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) **Mar. 19-1940** (b) **S. P. Ford** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

20. DATE OF DEATH Month **Mar** day **8** year **1940** hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Due to.....  
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 **J. Underwood** (M. D. or other).....  
Address **partville** date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

