

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 133

Primary Registration District No. 4074

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Boyard mo
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether _____)
In this community _____ years, months or days 1111

3. (a) PRINT FULL NAME Angeline Shirley
3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced unmarried
6. (b) Name of husband or wife Tom Shirley 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 16 1952
(Month) (Day) (Year)

8. AGE: Years 83 Months 6 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER { 12. Name W.P. Thomas 1
13. Birthplace Mo (City, town, or county) (State or foreign country)
14. Maiden name A. Shirley
15. Birthplace Mo (City, town, or county) (State or foreign country)

16. (a) Informant Frank Shirley

(b) Address Carrollton mo

17. (a) Burial (b) Date thereof Jun 28 1980
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Smith

18. (a) Signature of funeral director E. Decker

(b) Address Boyard mo

19. (a) 6-28-1980 (b) Janis Henderson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll
(c) City or town Boyard
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26
year 1980 7 P.M. 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 Apoplexy

Due to _____

Other conditions (Include pregnancy within 3 months of death) stroke

Major findings: Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? Boyard Carroll mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

120 While at work? (Specify type of place) (e) Means of injury 5

23. Signature E. Decker (M. D. or other) Carroll

Address Boyard mo Date signed 6/27/80

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

Date Filed 7-15-40
District File Number

District Health Officer No. 8

RECEIVED

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 E. G. Dickerson

Licensed Embalmer No. 2534

P. O. Address Bozard Ave

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.