

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

26095

State File No. _____

Registration District No. 744

Primary Registration District No. 3035

Registrar's No. 67

1. PLACE OF DEATH:
 (a) County Ray
 (b) City or town Richmond Mo.
 (c) Name of hospital or institution: home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: 3 yrs In hospital or institution (Specify whether years, months or days)

3. (a) PRINT FULL NAME Catherine Shirkey
 (b) If veteran, name war no
 (c) Social Security No. none

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife S. B. Shirkey Age of husband or wife if alive 25th years
 7. Birth date of deceased Nov. 25th 1844 (Month) (Day) (Year)

8. AGE: Years 95 Months 7 Days 10 If less than one day hr. min.

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

10. Usual occupation House Keeper

11. Industry or business _____

12. Name John Zeigler
 13. Birthplace Virginia (City, town, or county) (State or foreign country)

14. Maiden name Mrs. John Zeigler
 15. Birthplace Virginia (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Howard Lee Shuman
 (b) Address Richmond Mo.

17. (a) Funeral Co. (b) Date thereof July 1 th 1940 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Richmond Mo.

18. (a) Signature of funeral director J. J. Brothman
 (b) Address Richmond Mo.

19. (c) July 11-40 (b) Malcolm Jackson (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Ray
 (c) City or town Richmond Mo. (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. U.S.A. years

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 5th year 1940 hour 11:45 minute A. M.
 21. I hereby certify that I attended the deceased from 6-28-40 ~~7-5-40~~ 19____, to 7-5-40 19____; that I last saw her alive on 7-5-40 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia
 Due to Fractured hip
 Duration 3 days
 6 wks

Other conditions Myocarditis
 (Include pregnancy within 3 months of death) ?

Major findings:
 Of operations _____
 Of autopsy _____
 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? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature Thos J Cook (M. D. or other) M.D.
 Address Richmond, Mo. Date signed 7-12-40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very im-

USE OF THIS FORM IS PROHIBITED UNLESS AUTHORIZED BY THE BUREAU OF THE CENSUS

Handwritten scribbles

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 8-13-40

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.....

J.B. Brothers

....., Registered Apprentice No.....

working under my personal supervision.

Brothers Funeral Home

Signed *J.B. Brothers*

Licensed Embalmer No. **2001**

P. O. Address **Richmond Mo.**

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26095-**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **744**

Primary Registration District No. **3032-**

Registrar's No. _____

1. PLACE OF DEATH:
(a) County **Ray**
(b) City or town **Richmond**
(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)

3. (a) PRINT FULL NAME **Catherine Shirney**
(b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex **7** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **wid**
6. (b) Name of husband or wife _____
6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased: (Month) (Day) (Year)
8. AGE: Years **95'** Months **7** Days **10**
If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {
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) (Date received local registrar) _____ (b) (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.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **5-**
year _____ 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: **Bronchial Pneumonia**
Fractured Hip

Due to _____

Other conditions: **myocarditis**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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) **accident**
(b) Date of occurrence **June 30, 1940**
(c) Where did injury occur? **Richmond Ray Mo**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
home
While at work? **No** (Specify type of place)
(e) Means of injury **Fall**
23. Signature **Stos J. Cook** (M. D. or other) **M.D.**
Address **Richmond Mo** Date signed **8-7-40**

SUPPLEMENTAL

