

18 Oct 18 94

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

32506
Do not use this space.

1. PLACE OF DEATH

(a) County Mason Registration District No. 533

(b) Township Hudson Primary Registration District No. 5713

(c) City Mason (d) Street No. 2299 W. 11th St. Sanatoum St.
(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 SHELTON BIRKETT

(a) Residence, No. Wilbata Kane St. (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 10, 1886

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>84</u>	<u>2</u>	<u>13</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Cattle man

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

13. NAME Shelton Birkett

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England

15. MAIDEN NAME Wm. Bond

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT H. H. Birkett
(ADDRESS) Wilbata Kane, Mason

18. BURIAL: CREMATION, OR REMOVAL*
PLACE Oak Grove Cem DATE 8/24/40

19. FUNERAL DIRECTOR Albert Skinner
(ADDRESS) Mason, Mo.

20. FILED 10/4 1940 Geo. H. Keston
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 23, 1940

22. I HEREBY CERTIFY, That I attended deceased from JUNE 20, 1938, to SEPT. 23, 1940

I last saw him alive on SEPT. 23, 1940 Death is said to have occurred on the date stated above, at 2:10 AM.

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

SENILE DEMENTIA 2 1/2 yrs

Other contributory causes of importance:

GANGRENE 4 wks

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 ✓, 1940
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?
If so, specify ✓

(Signed) R. H. Zell M.D.
(Address) Mason Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS 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.

V. S. NO. 2.
DOM-7-20-37
X 12004

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RECEIVED

District Health Officer

District File Number. 10-40-1883

Date Filed OCT 9 1940

STATEMENT BY LICENSED EMBALMER

I, Joseph D. Phile, Licensed Embalmer No. 4066

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Joseph D. Phile

L. E. 4066

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Joseph D. Phile
Licensed Embalmer No. 4066

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32506
Registrar's No. 59

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
Registration District No. 330

Primary Registration District No. 0713

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

1. PLACE OF DEATH:
(a) County Madison
(b) City or town Anderson T.P.
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Skelton Birkett
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 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 84 Months 2 Days 13 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (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 Sept day 23 year 1940 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that he/she was h. _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Senile Dementia
Due to _____
Due to _____ 97
Other conditions _____ (Including pregnancy within 3 months of death)
Major findings: Gangrene. Due to arteriosclerosis
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 R. H. Stief D.O. (M. D. or other) _____
Address Macm. Mo. Date signed Nov. 29

SUPPLEMENTAL

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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