

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

BUREAU OF THE CENSUS
FILED NOV 25 1942

Registrar's No. 713

Registration District No. 128

Primary Registration District No. 2000

39
2
6

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

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1231 St. Louis 1
(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 77

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Springfield
(If outside city or town limits, write "RURAL")

(d) Street No. 1231 St. Louis
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 70 years 0

3. (a) PRINT FULL NAME MARY MARIA SHOCKLEY

(b) If veteran, name war None

(c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 5
year 1942 hour 5 minute A M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Stewart Shockley

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased August 19 1875
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July, 1940, to Oct. 5, 1942
that I last saw her alive on Oct. 1, 1942
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

1 67 1 16 hr. min.

Immediate cause of death: Pulmonary Edema
Chronic Atrophic Arthritis
Generalized Neuritis

Duration: 1 wk
5 yrs
2 yrs

9. Birthplace St. Thomas Ontario Canada
(City, town, or county) (State or foreign country)

Due to _____

Other conditions (Include pregnancy within 3 months of death) III C

10. Usual occupation None

11. Industry or business None

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Matthew Cole

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

14. Maiden name Emma Cain

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

16. (a) Informant Arthur Shockley

(b) Address Springfield Mo

17. (a) Burial (b) Date thereof October 7, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crest Lawn

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? _____

18. (a) Signature of funeral director Erud C. Urume

(b) Address Springfield Mo

19. (a) 10-7-42 (b) W. H. Davelly
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature W. H. Davelly (M. D. or other)

Address Springfield, Mo. Date signed _____

DEC 16 1947

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.....

R. H. Christie

Licensed Embalmer No.....

3681

P. O. Address.....

Springfield, Ma.

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, fact should be so stated above.