

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

Do not use this space.

36007

1. PLACE OF DEATH

County Ruchanan Registration District No. 85

Township St Joseph Primary Registration District No. 1001

City St Joseph (No. State Hospital #2) St. 1245 Ward

File No. _____
Registered No. 1245

2. FULL NAME

(a) Residence. No. State Hospital #2 Ward. _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mollie E Record

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7/11/1892

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
35 3 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Electrical Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kas
(STATE OR COUNTRY)

10. NAME OF FATHER Raymond S Shifflet

11. BIRTHPLACE OF FATHER (CITY OR TOWN) W. Va
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Nancy C. Claxton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) W. Va
(STATE OR COUNTRY)

14. INFORMANT Stak Hoop Record
(Address) St Joseph

15. John J. [Signature] REGISTRAR
FILED DEC 7 1927

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/4/27 19

17. I HEREBY CERTIFY, That I attended deceased from 10/7/25, 1927, to 12/4/27, 1927, that I last saw him 12/2/27 alive on 12/2/27, 1927, and that death occurred, on the date stated above, at 11:40 am.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

83 General Paresis
230A
Pul Tuberculosis (duration) 2 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) _____
(duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 710
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical
(Signed) [Signature], M. D.

(Address) Stak Hoop #2
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER Stak Hoop
Stak Hoop ADDRESS Dec 7 1927
602 So. 10th

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.

JAN 17 1928

WHILE IN EFFECT, WITH CHARGING THEREIN IS A PERMANENT RECORD

