

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

Do not use this space.

1. PLACE OF DEATH

County Monteau
Township _____
City Tipton (No. _____) St. _____ Ward _____

Registration District No. 5-75-
Primary Registration District No. H 339

File No. 10816
Registered No. _____

2. FULL NAME

Stella Augusta Shackelford
(a) Residence. No. _____ St. _____ 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 Female 4. COLOR OR RACE colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 6, 1880

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>50</u>	<u>10</u>	<u>13</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Tipton
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Calvin Shackelford

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Millie Howard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Missouri

14. INFORMANT Mrs. Edmer Perkins
(Address) Tipton, Mo

15. FILED 3-20-31 Miss Sarah J. Foy
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-19-1931

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at 8:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
(Patient died in 5 min. after I saw her first time.) Apoplexy. sudden. 82A
11B (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Had influenza about two weeks previous (duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No
WHAT TESTS CONFIRMED DIAGNOSIS? clinical
(Signed) B. F. Bowline, M. D.

3-20-1931 (Address) Tipton, Mo.

*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 Tipton, colored cemetery
Tipton, Mo. DATE OF BURIAL 3-20-1931

20. UNDERTAKER Genelle E. Richards ADDRESS Tipton, Mo

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.

APR 24 1931

