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

Do not use this space.

1078

1. PLACE OF DEATH
County Howard — Registration District No. 378
Township — Primary Registration District No. 4222
City Fayette (No. ____ St. ____ Ward) — File No. ____ Registered No. 3

2. FULL NAME Walter Scott Shifflett

(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. 7 da. How long in U.S., if of foreign birth? ____ yrs. ____ mos. ____ da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

5a. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF: Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 16 1907

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	23	4	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Practical Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 146
(c) Name of employer

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

PARENTS

10. NAME OF FATHER W.W. Shifflett
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ____ (STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Maud Wasson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ____ (STATE OR COUNTRY) Kentucky

14. INFORMANT W.W. Shifflett
(Address) Armstrong Mo

15. FILED 1-30, 19 31 V. A. Bonham REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-12 1931

17. I HEREBY CERTIFY, That I attended deceased from Jan 9, 1931, to Jan 12, 1931, that I last saw h[illegible] alive on Jan 12 1931, and that death occurred, on the date stated above, at 9 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Internal Hemorrhage
(duration) ____ yrs. ____ mos. 1 da.
CONTRIBUTORY (SECONDARY) Streptococcic Sore Throat
(duration) ____ yrs. ____ mos. 8 da.

18. WHERE WAS DISEASE CONTRACTED 103
IF NOT AT PLACE OF DEATH? ____
DID AN OPERATION PRECEDE DEATH? No DATE OF ____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) W A [illegible], M. D
, 19 (Address) Fayette 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	DATE OF BURIAL
Walnut Ridge	1-14 1931
20. UNDERTAKER A.H. Alldaker	ADDRESS Armstrong Mo

WHITE 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.