

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

Do not use this space.

43313

1. PLACE OF DEATH

County Wright
Township Wood
City Mountain Grove (No. 18)

Registration District No. 901
Primary Registration District No. 6223

File No. _____
Registered No. 49
St. _____ Ward _____

2. FULL NAME Charley Shiflett

(a) Residence. No. On farm three miles from town waarth,
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct, 27, 1870

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
59 I 7

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

9. BIRTHPLACE (CITY OR TOWN) New Holand
(STATE OR COUNTRY) Ohio

PARENTS

10. NAME OF FATHER Wm. Henry Harison Shiflett
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Sharlottville
(STATE OR COUNTRY) Virginia,
12. MAIDEN NAME OF MOTHER Rebeca Lively
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Ohio

14. INFORMANT J. M. Shiflett
(Address) Golden City Mo.

15. FILED 12/20, 1929 J. M. Hubbert REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec, 5 th 1929

17. 12 HEREBY CERTIFY, That I attended deceased from 12-2-1929 to 12-5-1929, 1929, that I last saw him alive on 12-4, 1929, and that death occurred, on the date stated above, at 3:45 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Opoplexy Cerebral
31 (duration) yrs. mos. 2 ds.

CONTRIBUTORY nephritis (SECONDARY) (duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? no
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? 12/6 1929
(Signed) Ray P. B. Bailey M. D.
(Address) Mountain Grove 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 Headville Mo, DATE OF BURIAL Dec. 8th, 1929

20. UNDERTAKER* N.L. Botten ADDRESS Mountain Grove Mo.

WRITE FAINLY, 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.

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