

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.

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

PLACE OF DEATH

County Bellinger

Township Brookfield

Village _____

City _____ (NO. _____)

Registration District No. 998

Primary Registration District No. 5103

File No. 15692

Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Shadric Cheek

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

White

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widower

DATE OF BIRTH

April 21, 1832
(Month) (Day) (Year)

AGE

81 yrs. 10 mos. 22 ds.
If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

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BIRTHPLACE

(City or town, State or foreign country)

Jill.

NAME OF FATHER

Unknown

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Jill.

MAIDEN NAME OF MOTHER

Unknown

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

May 1, 1913 W. J. Myers
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

May 15, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 1, 1913, to Feb 28, 1913, that I last saw him alive on Feb 28, 1913,

and that death occurred, on the date stated above, at 1 P.m.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory

(SECONDARY)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

H. J. Kelly

M. D.

April 8, 1913

(Address) Patton Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Carmel Feb 17, 1913

UNDERTAKER

ADDRESS

None None

PLACE OF DEATH

County _____
 or
 Township _____
 or
 Village _____
 or
 City _____

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

Registration District No. _____ File No. _____
Primary Registration District No. _____ Registered No. _____
St. _____ Ward _____
[If death occurred in a hospital or institution, give its NAME instead of street and number]

If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (<i>Write the word</i>)
DATE OF BIRTH		
		_____ / _____ / _____ (Day) (Month) (Year)
AGE	If LESS than _____ yrs. _____ mos. _____ ds. 1 day _____ hrs. _____ min. ?	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191_____,
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191_____, to _____, 191_____,
that I last saw h_____ alive on _____, 191_____,
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(City or town,
State or foreign country)

NAME OF FATHER

BIRTHPLACE
OF FATHER

(City or town, State or foreign country)

MAIDEN NAME
OF MOTHERBIRTHPLACE
OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)...

Filed

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REGISTRAR

PLACE OF BURIAL OR REMOVAL

UNDERTAKER

DATE OF BURIAL

ADDRESS -