WRITE 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.

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

PLACE OF DEATH

County Moniteau

Township ____ or Village ____ or City Tipton (NO. ____ St.: ____ Ward)

Registration District No. 575 File No. 5473

Primary Registration District No. 4339 Registered No. 3

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

FULL NAME John Cavil Schackleford

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

COLOR OR RACE: black

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

DATE OF BIRTH: Jan (Month) 1 (Day), 1839 (Year)

AGE: 75 yrs. 1 mos. 11 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer, Gardening
(b) General nature of industry, business, or establishment in which employed (or employer): sawing wood etc.

BIRTHPLACE (City or town, State or foreign country): Moniteau Co. Mo.

PARENTS
NAME OF FATHER: Robert Schackleford
BIRTHPLACE OF FATHER (City or town, State or foreign country): Kentucky
MAIDEN NAME OF MOTHER: Don't know
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nellie G. Schackleford

(ADDRESS) Tipton, Mo

Filed Feb 12, 1914. Frank D. Villiss REGISTRAR

MEDICAL CERTIFICATE OF DEATH 3

DATE OF DEATH: Feb (Month) 12 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 12, 1913, to Nov 1, 1913, that I last saw him alive on Nov 1st, 1913, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows: Not known, Probably heart failure or apoplexy (Died suddenly)

(Duration) 3 yrs. — mos. — ds.

Contributory (SECONDARY) Mitral insufficiency

(Duration) — yrs. 6 mos. — ds.

(Signed) Frank D. Villiss M. D.

2-12, 1914 (Address) Tipton, Mo

*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: [illegible]

PLACE OF BURIAL OR REMOVAL: Tipton, Mo

DATE OF BURIAL: Feb. 15 1914

UNDERTAKER: [illegible] Patterson

ADDRESS: Tipton, Mo

Revised United States Standard Certificate

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

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred hospital or institu give its NAME in of street and numbe

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day) 1_____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

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)

PARENTS
- NAME OF FATHER
- BIRTHPLACE OF FATHER (City or town, State or foreign country)
- MAIDEN NAME OF MOTHER
- BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____, 19__ (Y

I HEREBY CERTIFY, that I attended deceased f _____, 191__, to _____, 191 that I last saw h_____ alive on _____, 191 and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____

Contributory _____ (SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____

(Signed) _____

_____, 191__ (Address) _____

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

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

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

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191
UNDERTAKER	ADDRESS