

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

Do not use this space.

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1. PLACE OF DEATH
 County Polk Registration District No. 705
 Township Benton Primary Registration District No. 5934
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Alfred V Shadwick
 (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.

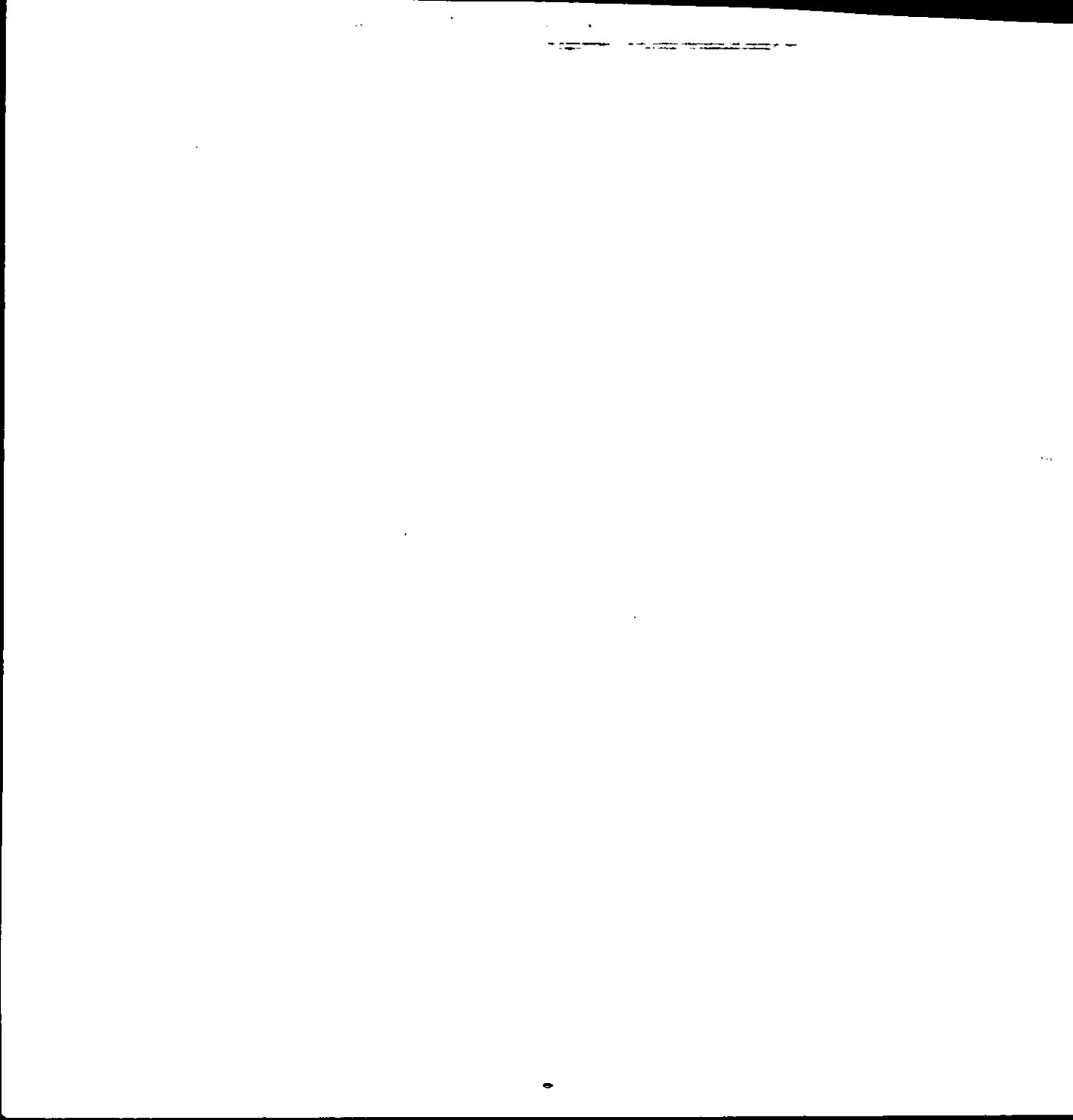
PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Married
 (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sallie M Shadwick
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 25-1851
7. AGE YEARS 75 MONTHS 3 DAYS 16
 If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED Farmer ³²¹ ₉₇
 (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) Mo
 (STATE OR COUNTRY)
10. NAME OF FATHER Nelson Shadwick
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo
 (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Ann
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo
 (STATE OR COUNTRY)
14. INFORMANT A. J. Shadwick
 (Address) Buffalo Mo
15. FILED Dec 12 1927 A. W. Glover REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 11 1927
17. I HEREBY CERTIFY, That I attended deceased from July 27 1927, to Dec 11 1927, and that I last saw him alive on Dec 10 1927, and that death occurred, on the date stated above, at 7-40 a.m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arterio Sclerosis
75 (duration) 3 yrs. 3 mos. 18 ds.
 CONTRIBUTORY (SECONDARY) Hemiplegia
 (duration) yrs. 3 mos. 18 ds.
18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? _____
19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) T. O. Winkler, M. D.
Dec 12 1927 (Address) Halfway Mo
 *State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Schofield **DATE OF BURIAL** Dec 12 1927
20. UNDERTAKER Hutchinson Bros **ADDRESS** Polivar



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Polk Registration District No. 205- File No. _____
 Township Benton Primary Registration District No. 9-934 Registered No. 12
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Alfred V. Shadwick
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 28 1864

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
2 63 3 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT _____ (Address) _____

15. FILED Nov 16 19 27 C. M. Glover REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 11 19 27

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.
 _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 (Address) _____

*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

20. UNDERTAKER ADDRESS

19

SUPPLEMENTARY

UN... THEY ARE COMPLETE AS PRESCRIBED BY LAW

PARENTS SHALL NOT RE

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