

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

Do not use this space.

21167

1. PLACE OF DEATH

County Henry
Township Millers
City St. Elizabeth (No. _____)

Registration District No. 313
Primary Registration District No. 5-1-3-2

File No. _____
Registered No. 3
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

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

FF.

4. COLOR OR RACE

NO.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

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

Oct-11-1892

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, _____ hrs. _____ or _____ min.

36

8

15

8. OCCUPATION OF DECEASED

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

None

(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)

St. Louis, Mo.

10. NAME OF FATHER

Fredrick Shidler

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

St. Louis, Mo.

12. MAIDEN NAME OF MOTHER

Christina W. Shidler

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

St. Louis, Mo.

14.

INFORMANT (Address)

Fredrick Shidler
Barlington RR #1

15.

FILED

19

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Jan 26 - 1929

17.

HEREBY CERTIFY, That I attended deceased from May 1, 1929 to June 26, 1929. that I last saw h. er alive on June 29, 1929, and that death occurred, on the date stated above, at 7:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Progressive Muscular Atrophy (Sjögren)

81A
82D

Severe yrs. 1 mos. _____ ds.

CONTRIBUTORY (SECONDARY)

Complete Paralysis

(duration) yrs. 1 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) Rev. P. A. Little, M. D.

June 29, 1929 (Address) Spring City, 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

Berlin Cemetery

6-28-1929

20. UNDERTAKER

ADDRESS

R. S. Piggott

Spring City, Mo.

Lat. 10° 0' N
Long. 70° 0' W

DATE: _____

100

ed b. 1944
ad 1944

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'मोती पूजा'

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Lentz
Township Miller
City _____ (No. _____ St. _____ Ward _____)

Registration District No. 313
Primary Registration District No. 2432

File No. _____
Registered No. 3

2. FULL NAME

Nellie Belle Shidler
(a) Residence, No. Darlington #1 St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred all life yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 11 - 1892

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>36</u>	<u>8</u>	<u>15</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(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) S. Dakota

10. NAME OF FATHER

Fredrick Shidler

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Penn.

12. MAIDEN NAME OF MOTHER

Christine Wied

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ill

14.

INFORMANT Fredrick Shidler
(Address) Darlington R.R. #1

15.

FILED 731, 1929 D. F. Westfall
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 26 1929

17. I HEREBY CERTIFY that I attended deceased from May 1 1929, to June 26 1929, that I last saw him/her alive on June 23 1929, and that death occurred, on the date stated above, at 1:30 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Progressive muscular atrophy (Spinal)
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Complete Paralysis
(SECONDARY) (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) R. W. Ouellette, M. D.
June 28 1929 (Address) King City 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Berlin Cemetery

6-28-1929

20. UNDERTAKER

ADDRESS

R. G. Taggart

King City

N.B. - This certificate should be carefully filled out. AGE should be stated in years, months, and days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact status of OCCUPATION is required. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

