

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.

24254

1. PLACE OF DEATH

County Linn
Township Linn
City (No.)

Registration District No. 288
Primary Registration District No. 5404

File No.
Registered No.
St. Ward)

2. FULL NAME

William Riley Sheppard

(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W. 5. ~~SINGLE~~ MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75

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

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

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT R. W. Mathis
(Address) RT 2, Holcomb, Mo

15. FILED 7/9, 1929 J. Anderson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-1 1929

17. I HEREBY CERTIFY, That I attended deceased from 6-16, 1929, to 7-1, 1929, that I last saw him alive on 6-29, 1929, and that death occurred, on the date stated above, at 2 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Intestinal Obstruction
(duration) yrs. 6 mos. ds.

*CONTRIBUTORY (SECONDARY) 1290
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Home
IF NOT AT PLACE OF DEATH.

19. DID AN OPERATION PRECEDE DEATH? No DATE OF ...

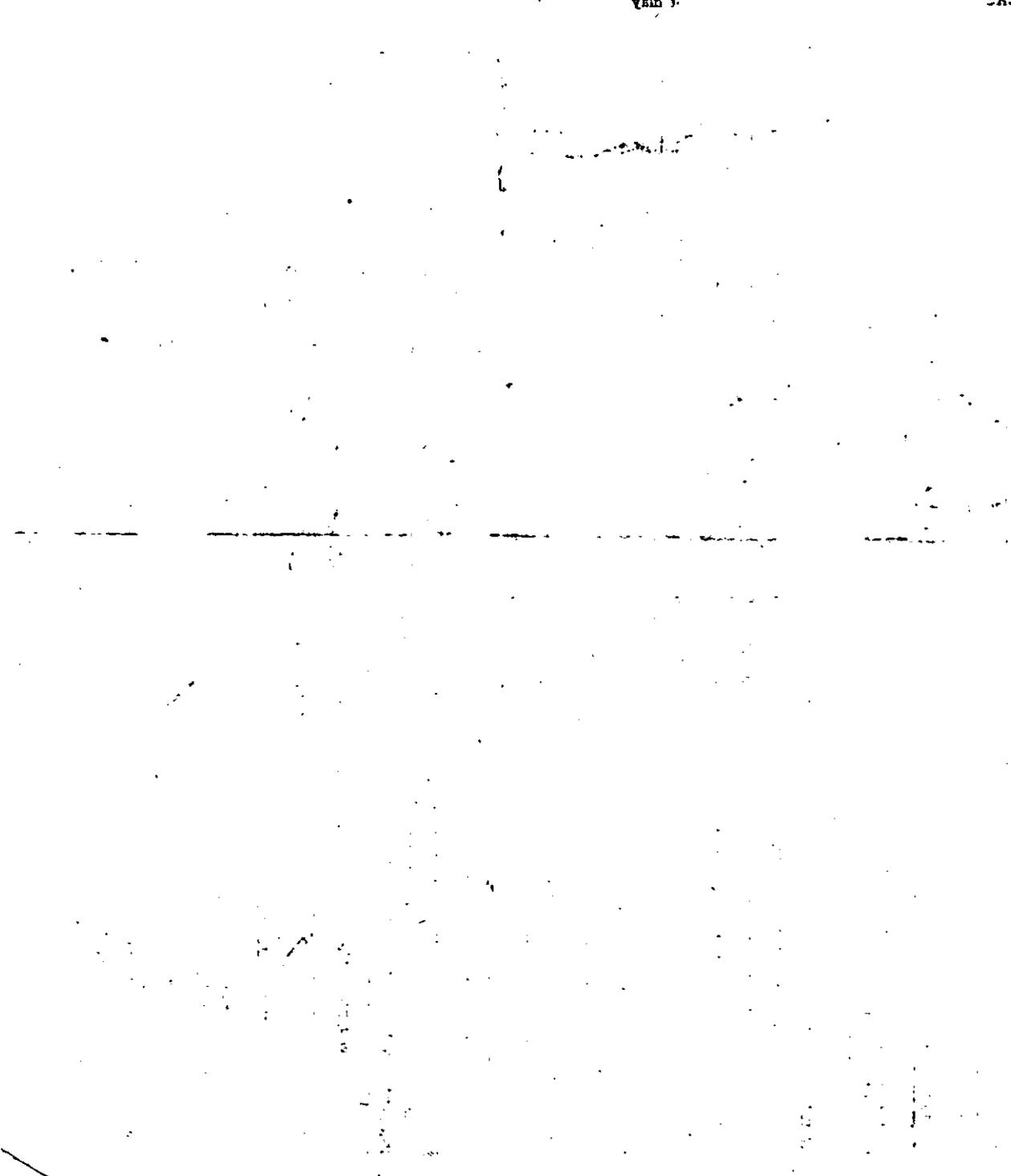
20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS exam
(Signed) S. T. Smith, M. D.
72, 1929 (Address) Holcomb, 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 Mo Holcomb DATE OF BURIAL July 2, 1929

20. UNDERTAKER W. C. Lunsdell ADDRESS Holcomb, Mo



**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 Dunklin
Township 2nd
City (No. St. Ward)

Registration District No. 288
Primary Registration District No. 3404

File No. 80
Registered No.

2. FULL NAME

William Riley Sheppard
(a) Residence. No. St. Ward. (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 (write the word) wid

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 75

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(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) mo

10. NAME OF FATHER unknown

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 L. A. Mathews
(Address) Rt 2, Osceola

15. FILED 9/9, 19 29 Thur Davis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 1 19 29

17. I HEREBY CERTIFY that I attended deceased from 6-16-29 to 7-1-29 that I last saw him alive on 6-29-29 and that death occurred, on the date listed above, at 2:25 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Interstitial Nephritis

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH home

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none
(Signed) S. J. Smith, M. D.

1/2, 19 29 (Address) Osceola 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 Mc Cullough DATE OF BURIAL July 2 19 29

20. UNDERTAKER A. C. Lassdell ADDRESS Kennett mo

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

THIS IS A SUPPLEMENTARY RECORD

[Faint, mostly illegible text, possibly a list or report. Some words like "REPORT", "ITEM", "NO." are visible.]

S-24254

CONFIDENTIAL