

21 1939

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

Do not use this space.

36636

1. PLACE OF DEATH

County Clark
Township Des Moines
City..... (No..... St..... Ward)

Registration District No. 193
Primary Registration District No. 5270

File No.....
Registered No.....

2. FULL NAME

Morris Walton Sheffler

(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. 10 mos. 5 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 14 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
10 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Des Moines Iowa
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Frank Sheffler

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

12. MAIDEN NAME OF MOTHER Melba Ward

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

14. INFORMANT Frank Sheffler
(Address) Alexandria Mo

15. FILED 11 26 39 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-19 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1929, to Nov 19, 1929, that I last saw him alive on Nov 18, 1929, and that death occurred, on the date stated above, at 12:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

bronchopneumonia
107A

100 W yrs. 22 ds.

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

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

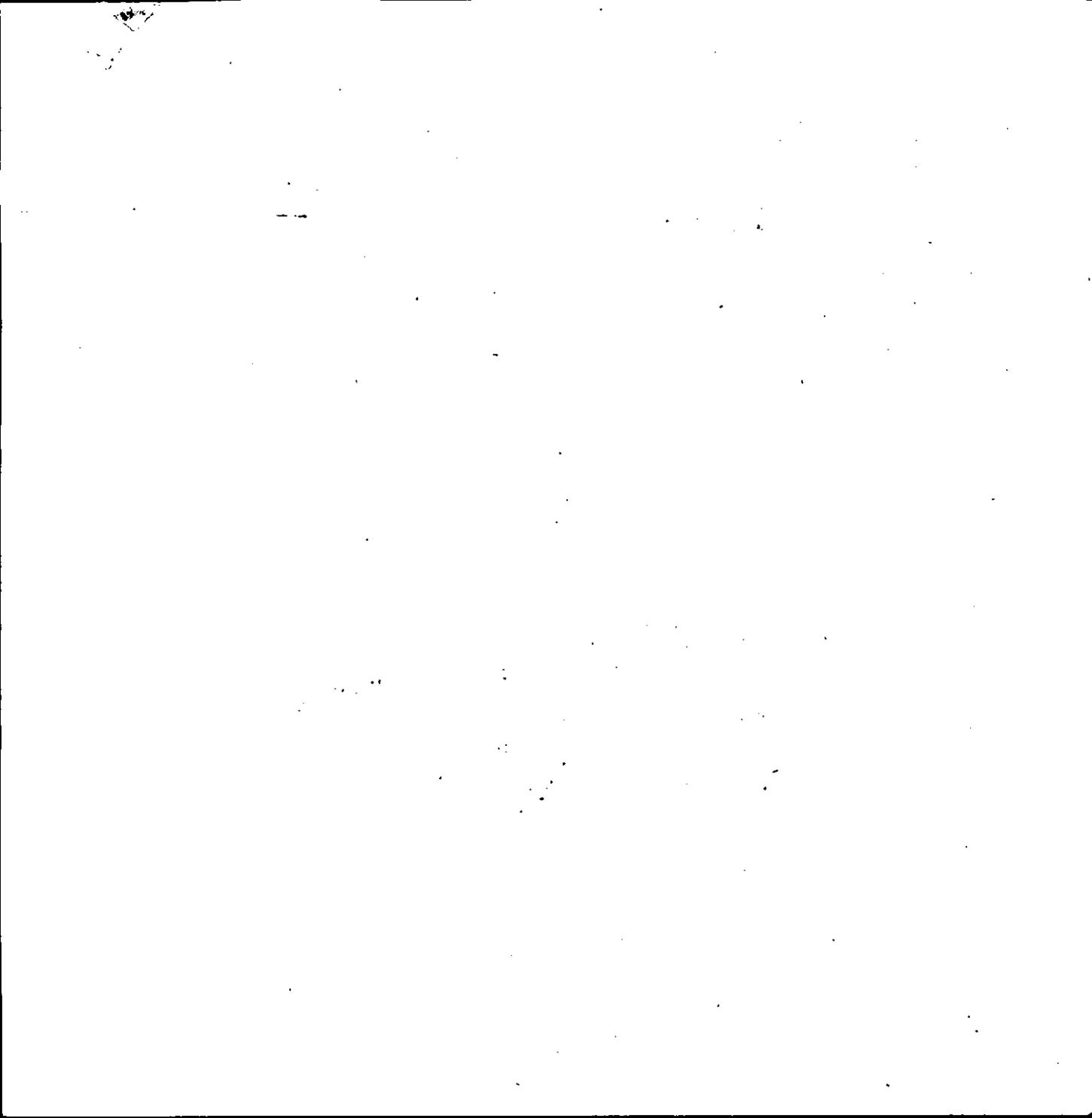
19. DID AN OPERATION PRECEDE DEATH? no DATE OF..... WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS..... (Signed) H.W. Harris, M. D. 19 (Address) Quincy 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 Bluff Spring DATE OF BURIAL 11-20 1929

20. UNDERTAKER H.F. Kircho ADDRESS Wayland



**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 Clark Registration District No. 193 File No. _____
 Township Des Moines Primary Registration District No. 3270 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Morris Wilton Sheffler

(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 S (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 14 1920

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
10 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child (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) Des. Moines twp
 (STATE OR COUNTRY) _____

10. NAME OF FATHER Frank Sheffler

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

12. MAIDEN NAME OF MOTHER Mabel Ward

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) McDonald Co. 111.

14. INFORMANT Frank Sheffler

(Address) Alexandria, Mo.

15. FILED 11-26-20 H. F. Kircher

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-19-20

17. I HEREBY CERTIFY, That I attended deceased from Apr. 28 to Nov. 10, 1920
 that I last saw him, alive on Nov. 18, 1920, and that death occurred, on the date stated above, at 12:50 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) H. W. Harris, M. D.

, 19 (Address) Canton, 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

Eluff Springs

11-20 1920

20. UNDERTAKER

H. F. Kircher

ADDRESS

Wayland

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

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