

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

Do not use this space.

40283

**1. PLACE OF DEATH**

County Genney Registration District No. 314  
Township Cooper Primary Registration District No. 349 B  
City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 45

**2. FULL NAME**

William Allen Shuler

(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) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE Belle Shuler (deceased)

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 24 - 1855

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
74 10 17

**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) Davenport  
(STATE OR COUNTRY) Iowa

10. NAME OF FATHER Enriam Shuler

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

12. MAIDEN NAME OF MOTHER Jane Buffington

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

14. Informant Miss Lena Shuler  
(Address) Stanbury, MO 137

15. FILED 12/13/29 REGISTRAR W. H. Remick

**MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY, That I attended deceased from Dec. 10 1929 to Dec. 11 1929  
that I last saw him alive on Dec. 11 1929, and that death occurred, on the date stated above, at 12:30 m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Uremic Poisoning  
132 A  
132 B  
(duration) yrs. mos. ds.

CONTRIBUTORY (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) Jas. A. Conkern, M. D.  
12/11 1929 (Address) Stanbury, 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 Hall Cemetery MO  
DATE OF BURIAL 12/14/29

20. UNDERTAKER Lafayette H. Phillips  
ADDRESS Stanbury, 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 St. Louis  
Township Cooper  
City St. Louis (No. 314)

Registration District No. 314

Primary Registration District No. 3429

File No. 43-

Registered No. 43-

St. St. Louis Ward 43-

**2. FULL NAME**

William Allen Shuler

(a) Residence. No. St. Louis Ward 43-  
(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 w (write the word)

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

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

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

8. OCCUPATION OF DECEASED

- (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) (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

2/10/30

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 11 19 29

17.

I HEREBY CERTIFY, That I attended deceased from

that I last saw h. alive on to 18. and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Unnatural Poisoning  
Breast Disease

CONTRIBUTORY (SECONDARY)

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) Gas. A. Carochin, M. D.

710, 1930 (Address) St. Louis, 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

20. UNDERTAKER

ADDRESS

19

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETELY

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