

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

Do not use this space.

**AUG 20 1930**

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.

14 2 9

**22126**

**1. PLACE OF DEATH**

County Callaway Registration District No. 104  
Township Fulton Primary Registration District No. 3008  
City Fulton St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 167  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Wiel Shockley  
(a) Residence. No. State Hosp #1 St. H-2 Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 1 yrs. 1 mos. 26 ds. How long in U.S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
-----------------------	----------------------------------	---

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. _____ min.
<u>Unknown</u>	<u>about</u>	<u>6</u>	<u>1/2</u>	<u>yr.</u>

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer) No information  
(c) Name of employer No information

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Unknown

10. NAME OF FATHER No information

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) No information

12. MAIDEN NAME OF MOTHER No information

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

14. INFORMANT Record of State Hosp #1 (Address) Fulton, Mo

15. July 16, 1930 T. H. Crews REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 18 1930  
17. I HEREBY CERTIFY, That I attended deceased from June 28, 1930, to July 18, 1930 that I last saw him alive on July 17, 1930 and that death occurred, on the date stated above, at 4:30 AM

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Diphtheria, septicaemia  
83  
34

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
CONTRIBUTORY (SECONDARY) General Paralysis of Insane  
(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 none except autopsy  
(Signed) C. C. Alett, M. D.  
, 19 \_\_\_\_\_ (Address) Fulton, 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 <u>Columbia Mo</u>	DATE OF BURIAL <u>DK</u> 19 _____
--	--------------------------------------

20. UNDERTAKER <u>J. B. Roberts</u>	ADDRESS <u>Columbia Mo</u>
--	-------------------------------

