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

Do not use this space.

23458

1. PLACE OF DEATH
County: Lincoln
Township: Bedford
City: (No. ... St. ... Ward)
Registration District No. 491
Primary Registration District No. 5654
File No.
Registered No. 31

2. FULL NAME: Joseph P Shelker
(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: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND~~ OF (OR) WIFE OF: Ida Shelker

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 24 - 1840

7. AGE

| YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|
| 90 | 7 | 0 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer 131
(b) General nature of industry, business, or establishment in which employed (or employer): 93
(c) Name of employer: 116

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Bohema

PARENTS
10. NAME OF FATHER: Joe Shelker
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Bohema
12. MAIDEN NAME OF MOTHER: Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Bohema

14. INFORMANT (Address): Jim Shelker, Troy Mo

15. FILED 7/25, 1930 W P Smith, REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 24 1930

17. I HEREBY CERTIFY, That I attended deceased from 1908 June, 1908, to July 24, 1930 that I last saw h... alive on July 20, 1930, and that death occurred, on the date stated above, at 8 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Complication of Diseases Heart and Kidneys and Old Age.
(duration) ... yrs. ... mos. ... ds.

*CONTRIBUTORY (SECONDARY): Old Age.
(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? Clinical
(Signed) E. G. Hicks, M. D.
, 19 (Address) Troy 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: Douglas Cemetery
DATE OF BURIAL: 7-25 1930

20. UNDERTAKER: Kemper Bros
ADDRESS: Troy 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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should [illegible] 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

**1. PLACE OF DEATH**

County Lincoln — Registration District No. 491 — File No. .....

Township Bedford — Primary Registration District No. 5654 — Registered No. 31

City ..... (No. ..... St. ..... Ward)

**2. FULL NAME** Joseph P Sheeker

(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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) |
|---|---|---|
| M | W | Wid |

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)

PARENTS
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 9/8, 1930 W P Smith REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 24 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Complication of diseases
Heart and Kidneys
Chronic Nephritis
..... (duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY) Chronic Heart disease
..... (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) E. A. Hicks, M. D
9/8, 1930 (Address) Bray, 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 19 |
|---|---|
| 20. UNDERTAKER | ADDRESS |

SUPPLEMENTARY

S-23458