WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County Monitaau

Township ____ or Village ____ or City Tipton

Registration District No. 575 — File No. 5473

Primary Registration District No. 4339 — Registered No. 3

(NO. ____ St.; ____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME John Cavil Schacklyford

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	black	married

DATE OF BIRTH: Jan (Month) 1 (Day) 1839 (Year)

AGE: 75 yrs. 1 mos. 11 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer, Gardin
(b) General nature of industry, business, or establishment in which employed (or employer): Farm

BIRTHPLACE (City or town, State or foreign country): Monitaau Co. Mo.

PARENTS

NAME OF FATHER: Robert Schacklyford

BIRTHPLACE OF FATHER (City or town, State or foreign country): Kentucky

MAIDEN NAME OF MOTHER: Dont know

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nellie E Frazer

(ADDRESS) Tipton, Mo

Filed Feb 12. 1914. Frank D Willis REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb (Month) 12 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 12, 1913, to Feb 1, 1913, that I last saw him alive on Mar 1st, 1913, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Not known, Probably heart failure or apoplexy (Died suddenly)

(Duration) 3 yrs. — mos. — ds.

Contributory (Secondary) Mitral insufficiency

(Duration) — yrs. 6 mos. — ds.

(Signed) Frank D Willis M. D.

2-12, 1914 (Address) Tipton, Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Tipton, Mo	Feb. 15 1914
UNDERTAKER	**ADDRESS**
P. O. Patterson	Tipton, Mo

PLACE OF DEATH

County

Township
or
Village
or
City (NO. , St.: Ward)

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

Registration District No. File No.

Primary Registration District No. Registered No.

[If death occurred hospital or institu give its NAME in of street and numbe

Revised United States Standard Certificate

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH

(Month) (Day) , 1 (Year)

AGE

yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed , 191 ,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month) (Day) , 19 (Y

I HEREBY CERTIFY, that I attended deceased f , 191 , to , 191

that I last saw h alive on , 191

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos.

Contributory
(SECONDARY)

(Duration) yrs. mos.

(Signed) M

, 191 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL , 191
UNDERTAKER	ADDRESS