SEP 28 1927

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

Do not use this space.

24196

1. PLACE OF DEATH
County: Howell
Township: Howell
City: (No. ..... St. ..... Ward)
Registration District No. 384
Primary Registration District No. 4777
File No. 173
Registered No.

2. FULL NAME Dallas Schelling

(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): Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(or) WIFE OF~~ Emma Schelling

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 1st

7. AGE: Years 57 | Months 9 | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) Leaf River
(STATE OR COUNTRY) Ill

PARENTS

10. NAME OF FATHER Henry Schelling
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Md
12. MAIDEN NAME OF MOTHER Susan Horan
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Dont Know

14. INFORMANT Mrs Emma Schelling
(Address) Peace Valley Mo

15. FILED 8-27-19 27 O. A. Heinrich
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-19 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 16, 1927, to Aug 19, 1927, that I last saw b. alive on Aug 19, 1927, and that death occurred, on the date stated above, at 2.30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

117 - Peritonitis, acute general, 1 hr
167 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 126 (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) Edelande Bohrer, M. D
8-24, 1927 (Address) West Plains, 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 Antioch
DATE OF BURIAL 8-27 1927

20. UNDERTAKER M. Harland Und. Co
ADDRESS West Plains Mo.

N. B.—Accuracy in the description 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 [illegible]. AGE [illegible] EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. [illegible] 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: Dowell — Registration District No.: 384 — File No.: 79

Township: " " — Primary Registration District No.: 3333 — Registered No.:

City: (No. , St. Ward)

2. FULL NAME Dallas Schelling

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-1 1869

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 8-27-1927 O. A. Heinrich
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19 1927

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:
117- Peritonitis, acute general
Dont know
(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) , M. D
, 19 (Address)

*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-24196