SEP 28 1927

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

Do not use this space.

24604

1. PLACE OF DEATH

County: Jackson — Registration District No.: 400 — File No.:

Township: Prairie — Primary Registration District No.: 5553 B — Registered No.: 93

City: ~~Lee's Summit~~ (No. ..... St. ..... Ward)

2. FULL NAME Norma Lillian Sheldon

(a) Residence. No. Long View Farm 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)
female	White	Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 18-1927

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
		3 ~~4~~	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Child

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Lees Summit
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Edward Sheldon

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

12. MAIDEN NAME OF MOTHER Lillian Middleton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Taney Co
(STATE OR COUNTRY) Missouri

14. INFORMANT Edward Sheldon
(Address) Long View Farm

15. FILED Aug 8 1927 F. M. Schick REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 7th 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 3, 1927, to Aug 7, 1927, that I last saw her alive on Aug 7, 1927, and that death occurred, on the date stated above, at 1:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Poliomyelitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) None

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? None

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms

(Signed) F. J. Ragsdale, M.D.

, 19 (Address) Lees Summit 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
Lee's Summit Cem.	Aug 8 1927
20. UNDERTAKER	**ADDRESS**
W. L. Schick & Son	Indys, 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.