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

REC'D MAR 15 1939

6657
Do not use this space.

1. PLACE OF DEATH
(a) County Henry — Registration District No. 347
(b) Township White Oak — Primary Registration District No. 5495 — Registered No.
or
(c) City Urich Mo — (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 20 yrs. mos. ds. (f) How long in U. S., if of foreign birth? 70 yrs. 6 mos. 6 ds.

2. PRINT FULL NAME Ira Oscar Shultz
(a) Residence, No. Urich Mo St. ☐
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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~~: Alice Shultz
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE: YEARS 70 — MONTHS 6 — DAYS 6 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. General Farm work
10. Date deceased last worked at this occupation (month and year) Dec 1938
11. Total time (years) spent in this occupation 50

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Michigan

FATHER
13. NAME Don't Know
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Jessie Briggs, Kansas City, Mo
18. BURIAL, CREMATION, OR REMOVAL — PLACE Urich Cem. DATE Feb. 3 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. J. Brown, Urich Mo
20. FILED 2-7- 1939 Dr J R Hampton 312 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 2nd, 1939
22. I HEREBY CERTIFY, That I attended deceased from Jan 10th, 1939, to Feb 2nd, 1939
I last saw him alive on Jan 2nd, 1939. Death is said to have occurred on the date stated above, at 8:00 P. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage (Apoplexy)	1/10-39
Other contributory causes of importance: Hypertension	2 yrs?

Name of operation — Date of
What test confirmed diagnosis? Physical Was there an autopsy? —

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury ....., 19....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury
24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) J. E. McDonald, M. D.
(Address) Urich Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 7-39-33
Date Filed 3-3-39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

6667
Do not use this space.

1. PLACE OF DEATH
(a) County: Henry — Registration District No.: 347
(b) Township: White Oak — Primary Registration District No.: 347S — Registered No.:
(c) City: — (d) Street No.: St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME: Ira Oscar Shelty
(a) Residence, No.: St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): May-26-1868

7. AGE: Years 70 | Months 6 | Days 6 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.:
9. Industry or business in which work was done, as saw mill, bank, etc.:
10. Date deceased last worked at this occupation (month and year):
11. Total time (years) spent in this occupation:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY):

FATHER
13. NAME:
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY):

MOTHER
15. MAIDEN NAME:
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY):

17. INFORMANT (ADDRESS):

18. BURIAL, CREMATION, OR REMOVAL
PLACE: DATE: 19

19. FUNERAL DIRECTOR (ADDRESS):

20. FILED Feb-3 1939 Ora J. R. Hampton
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 2 - 2 , 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at .....m.
The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) J. G. McDaniel, M. D.
(Address) Windsor Mo.

SUPPLEMENTARY

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 COMPLETED AS PRESCRIBED BY LAW.