

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

24917
 Do not use this space.

1. PLACE OF DEATH **2**
 AUG 10 1939

(a) County Wendover Registration District No. 912
 (b) Township Van Allen Primary Registration District No. 4550 Registered No. 20
 (c) City Van Allen (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. da.

2. PRINT FULL NAME Thomas M Shelley
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary M Shelley
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 2 - 1874
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
64 9 26
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Care taker
 9. Industry or business in which work was done, as saw mill, bank, etc. Hayson Walker saw house
 10. Date deceased last worked at this occupation (month and year) July - 1939 11. Total time (years) spent in this occupation 21
 12. BIRTHPLACE (CITY OR TOWN) Saint Louis STATE OR COUNTRY Mo.
 FATHER 13. NAME Shelley
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont know
 MOTHER 15. MAIDEN NAME Dont know
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) " "
 17. INFORMANT Mrs. Mary M. Shelley (ADDRESS) Wendover Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE St Louis Mo DATE 7-22-39
 19. FUNERAL DIRECTOR (NAME) W. J. Natus (ADDRESS) Wendover Mo
 20. FILED July 20 1939 Carrie F. Utterback (Address) Wendover Mo
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 18 1939
 22. I HEREBY CERTIFY, That I attended deceased from July 18 1939, to July 18 1939
 I last saw him alive on July 18 1939. Death is said to have occurred on the date stated above, at 9 A.M.
 The principal cause of death and related causes of importance were as follows:
Acute dilatation of heart
 Other contributory causes of importance: Arteriosclerosis & chronic bronchitis
 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? No.
 If so, specify _____ (Signed) H. H. Bland, M. D.
 (Address) Wendover Mo

K. 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—THIS IS A PERMANENT RECORD

9562

RECEIVED

District Health Officer No. 10

District File Number 8-39-1389

Date Filed AUG 7 1939

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 W. B. Waters

Licensed Embalmer No. 3355-

P. O. Address Vandalia

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

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

RECEIVED
DISTRICT HEALTH OFFICER
AUG 7 1939

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

24914
Do not use this space.

1. PLACE OF DEATH

(a) County Dudman Registration District No. 912
(b) Township Vandalia Primary Registration District No. 4550 Registered No. 20
(c) City Vandalia (d) Street No. _____
(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 Thomas M Shelley

(a) Residence, No. _____ St. 8
(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) m

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.
64 9 26

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)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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 _____, 19__

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7 - 18 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ 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:

acute Dilatation of Heart
acute Myocarditis
Date of onset _____

Other contributory causes of importance:

Asthma + chronic Bronchitis

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) W. H. Bland, M. D.

(Address) Vandalia Mo.

SUPPLEMENT

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-24917 - 1939