

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.

Registration District No. 565 Primary Registration District No. 5761a

1. PLACE OF DEATH:
(a) County Miller
(b) City or town Brunley
(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township) 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days _____

3. (a) PRINT FULL NAME JOHN BENJAMIN SHELTON
3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Hazel Ann Shelton 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov - 14 - 1869
(Month) (Day) (Year)

8. AGE: Years 70 Months 3 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace Pulaski County, MO.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name Haman Shelton
13. Birthplace Tennessee
(City, town, or county) (State or foreign country)
14. Maiden name Martha Williams
15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Silbert Shelton
(b) Address Brunley, Mo.

17. (a) Burial (b) Date thereof 2-16-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Watkins, Mo.

18. (a) Signature of funeral director B. B. Casey
(b) Address Storia, Mo.

19. (a) 2/29/40 (b) C. K. Hawkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Miller
(c) City or town Brunley, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. R.T.D.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 15
year 1940 hour 12 minute 15 a.m.
21. I hereby certify that I attended the deceased from Feb. 10, 1940 to Feb 15, 1940
and that I last saw him alive on Feb. 14, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Labor pneumonia Duration Feb. 1 3 days
Due to acute influenza 7 days
Due to _____
Other conditions Adenitis sclerosic 15 years
(Include pregnancy within 3 months of death)
chronic nephritis

PHYSICIAN
Major findings: Of operations none
Of autopsy none
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
(Specify type of place) (e) Means of injury _____
While at work? _____
23. Signature Murray D. Jones (M.D. or other) MD
Address Brunley, Mo. Date signed 2-29-40

RECEIVED

Miller County Health Dep't.

County File Number 40-17

Date Filed 3-11-40

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

Loren Adams

, Registered Apprentice No. 211

working under my personal supervision.

Signed

O. B. Casey

Licensed Embalmer No. 2694

P. O. Address Iberia, Mo

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.