No. 2
11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13811

FILED MAY 15 1940

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 1523

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2
402 North Lawn
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community 48 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City, Missouri
(If outside city or town limit write "RURAL")

(d) Street No. 402 North Lawn
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Brown Shelton 435

3. (b) If veteran, name war None

3. (c) Social Security No. 702-14-5795

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Catherine E. Shelton

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased November (Month) 1 (Day) 1883 (Year)

8. AGE: Years 56 Months 5 Days 5 If less than one day ____ hr. ____ min.

9. Birthplace Overton (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Switchman

11. Industry or business Missouri Pacific R.R. 1

MOTHER FATHER

12. Name Holcomb Shelton

13. Birthplace Virginia (City, town, or county) ____ (State or foreign country) 0

14. Maiden name Matilda J. Smith

15. Birthplace Missouri (City, town, or county) ____ (State or foreign country)

16. (a) Informant Mrs. Catherine E. Shelton

(b) Address 402 North Lawn

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Mount Washington

18. (a) Signature of funeral director Mrs. Cl L. Forster

(b) Address 918 Brooklyn

19. (a) April 8, 1940 (Date received local registrar) (b) M. M. Browne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6 year 1940 hour 8 minute 45 P. M.

21. I hereby certify that I attended the deceased from April 15, 1939 to April 6, 1940 that I last saw him alive on April 6, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Primary Carcinoma of Larynx	1939
Due to 47	
Due to	
Other conditions (Include pregnancy within 3 months of death) See Ca. of Neck & Chest Wall	

Major findings:
Of operations as above
Laryngectomy
Of autopsy none

PHYSICIAN — 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)

While at work? Means of injury

23. Signature G. A. Roy (M. D. or other) M.D.

Address 100 Argyle Bldg Date signed 4/8/40

(Licensed Embalmer's Statement on Reverse Side)

4432 Liberty Vol 60/1
Avg of Co. Ha 5037
9 3rd St. Joseph Mo.
9 mos.

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 Theron A. Redmon

Licensed Embalmer No. 2737

P. O. Address K.C. Mo.

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

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