FILED AUG 9 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25556

Registration District No. 460 Primary Registration District No. 4273 Registrar's No. 29

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

1. PLACE OF DEATH:

(a) County Lafayette

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

(c) Name of hospital or institution: (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) All his life

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette

(c) City or town ~~Lexington~~ Dover (If outside city or town limits, write "RURAL")

(d) Street No. Rural (If rural, give location)

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

3. (a) PRINT FULL NAME J. C. Shelby 410

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife ✓

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

7. Birth date of deceased Sept (Month) 1 (Day) 1910 (Year)

8. AGE: Years 29 Months 10 Days 11 If less than one day hr. min.

9. Birthplace Lexington Mo (City, town, or county) (State or foreign country)

10. Usual occupation Grivilaid

11. Industry or business None

FATHER
12. Name James C Shelby
13. Birthplace Dover Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary V Warnell
15. Birthplace Dover Mo (City, town, or county) (State or foreign country)

16. (a) Informant Horace L Shelby

(b) Address 603 Roberts St Washington Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Mac Pelah C

18. (a) Signature of funeral director Fannie Funeral Home

(b) Address Concordia Mo

19. (a) July 15 40 (Date received local registrar) (b) Tiffany Webb (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11 year 1940 hour 11 minute 10 P.M.

21. I hereby certify that I attended the deceased from July 9, 1940, to July 11, 1940 that I last saw him alive on July 11, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Accidentally Shot through Upper Spinal Cord 15 yr ago - Invalid

Due to Respiratory paralysis

Due to Accident 15 yr ago

Other conditions — (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy no

Duration

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) Accident

(b) Date of occurrence Sept 5 - 1925

(c) Where did injury occur? Home - Lexington Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 413 no (Specify type of place)

While at work? — (e) Means of injury —

23. Signature B H Brasher (M. D. or other) M.D.

Address Lexington Mo Date signed 7/12/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 8-3-40

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 me

E. S. James Funeral Home, Registered Apprentice No.

working under my ~~personal~~ supervision.

assistance Signed Geo. A. Stoecklein

Licensed Embalmer No. 3369

P. O. Address Pilot Grove

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

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

No. 2B
-2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25-556

Registration District No. 460 Primary Registration District No. 4273 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Dover
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

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

3. (a) PRINT FULL NAME Joe C. Shelby

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased Sept (Month) 1 (Day) 1910 (Year)

8. AGE:

Years	Months	Days	If less than one day
29	10	11	hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Sept. 14-40 (Date received local registrar) (b) Tiffany Webb (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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? (e) Means of injury

23. Signature B. H. Brasher (M. D. or other)
Address Lexington Date signed