

FILED NOV 12 1940

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
General Hospital #2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8-16-40-9-1-40  
(Specify whether  
In this community 1 year  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limit write "RURAL")  
(d) Street No. Helping Hand (18th & Tracy)  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Sherman Shelton

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

4. Sex Male 5. Color or race Negro 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: 3 13 1910  
(Month) (Day) (Year)

8. AGE: Years 30 Months 5 Days 19 If less than one day hr. min.

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

10. Usual occupation none

11. Industry or business \_\_\_\_\_

12. Name Berry Shelton

13. Birthplace Texas  
(City, town, or county) (State or foreign country)

14. Maiden name Johnnie Lee

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

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) burial (b) Date thereof Oct 4-40  
(Funeral, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Reeds

18. (a) Signature of funeral director Wm. A. Johnson

(b) Address 1212 Main Street

19. (a) 10-4-40 (b) M. M. Grove  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9- day 1  
year 40 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from 8-16- 1940 to 9-1- 1940  
that I last saw him alive on 9-1- 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death:  
(1) Generalized peritonitis  
(2) Acute ulcerative colitis  
Due to perforation of caecum.  
(3) Dehydration

Other conditions (Include pregnancy within 3 months of death) 11x0 12

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

23. Signature J. O. Turner (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury !  
28. Signature J. O. Turner (M.D. or other)  
Address Gen. Hosp. #2 Date signed 9-2-40

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

MOTHER FATHER

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**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 comply with the above constitutes grounds for revocation of license.)**

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