

Registration District No. **35191941**Primary Registration District No. **5515**Registrar's No. **13**

## 1. PLACE OF DEATH

- (a) County Holt  
 (b) City or town RURAL Union Twp  
 (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 1 year \_\_\_\_\_ years, months or days) \_\_\_\_\_

3. (a) PRINT FULL NAME James Isaac Shelton

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Ethel Shelton 6. (c) Age of husband or wife if alive 40 years  
 7. Birth date of deceased Nov 26 1884  
 (Month) (Day) (Year)

8. AGE: Years 55 Months 11 Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace Clay Co. Mo.  
(City, town, or county) (State or foreign country)10. Usual occupation Farmer \_\_\_\_\_

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

- MOTHER FATHER  
 12. Name Tom Shelton  
 13. Birthplace Tenn.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Ruth Helman  
 15. Birthplace Tenn  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Ethel Shelton(b) Address Craig Mo.17. (a) Burial (b) Date thereof Nov. 5<sup>th</sup> 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Mr Hope Cemetery18. (a) Signature of funeral director Walter Crawford(b) Address Mount City Mo.19. (a) Nov 8 1940 (b) Veritas Baskin  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Holt  
 (c) City or town Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Union township  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 5<sup>th</sup>  
year 1940 hour 4 minute 0 M.21. I hereby certify that I attended the deceased from Oct 15, 1940 to Nov 5, 1940;  
that I last saw him alive on Nov 4, 1940  
and that death occurred on the date and hour stated above.Immediate cause of death Cardiac Asthma Duration 3 weeks

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?

3-30 While at work \_\_\_\_\_ (Specify type of place)  
Nature of injury \_\_\_\_\_23. Signature W. H. Baskin (M. D. county)  
Address Holt Mo Date signed 11/8/40

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed *A. C. Crawford*  
Licensed Embalmer No. 1824  
P. O. Address Mount City, 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.**