

3-40  
7-59  
MO:

FILED JUN 12 1941

Registration District No. 639

Primary Registration District No. 639 5843

Registrar's No. 157

1. PLACE OF DEATH:

(a) County Oregon

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

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 42 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME James Elishia Shehorn

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 Mattie Powell

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Sept. 25 1867  
(Month) (Day) (Year)

8. AGE: Years 73 Months 6 Days 27  
If less than one day hr. min.

9. Birthplace Hardin County / Tenn.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Ben Shehorn

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

14. Maiden name Catherine Bolen

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

16. (a) Informant Mrs. John D. King

(b) Address Alton, Mo.

17. (a) Burial (b) Date thereof 4/24/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hickory Grove

18. (a) Signature of funeral director

(b) Address Thayer, Mo.

19. (a) ✓ (b) ✓  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon 75

(c) City or town Alton -- Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. 0  
(If rural, give location)

(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22  
year 1941 hour 4 minutes P. M.

21. I hereby certify that I attended the deceased from April 20  
1941 to April 22, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Purulent Tuberculosis  
Myocardial Failure

Due to ASW

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

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

Of autopsy \_\_\_\_\_

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) \_\_\_\_\_

(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? 5/16

While at work? 5/16 (Specify type of place) \_\_\_\_\_

(e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) 0

Address [Signature] Date signed 4-29-41

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5,

File Number 64/1709

Date Filed .....

**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.....

.....  
working under my personal supervision.

Registered Apprentice No.....

Signed Leo Carr

Licensed Embalmer No. 2852

P. O. Address Thayer

**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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18591

Registration District No. 636

Primary Registration District No. 5843

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Oregon  
(b) City or town St. Lawrence T.P.  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James Elishia Shehorn  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Apr day 22  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex m 5. Color or race W  
6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_  
7. Birth date of deceased: \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
(Immediate cause of death) \_\_\_\_\_

8. AGE: Years 73 Months 6 Days 17  
If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

13. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. 'Maiden name' \_\_\_\_\_

15. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director Leo Carr

(b) Address Thayer Myroiri

19. (a) 4/24 1941 (b) Ercel C. Bailey  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_

23. Signature D. W. Cooper (M. D. or other) \_\_\_\_\_

Address Thayer Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-18591 1941