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

PARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 1 1943

Registration District No. 73

MISSOURI STATE BOARD OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 5729

Primary Registration District No. 5068

Registrar's No. 10

**1. PLACE OF DEATH:**
(a) County Barton (Woodsport Twp)
(b) City or town Sheldon Mo Star R. 1
(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)
In this community 2 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Mo (b) County Barton 6
(c) City or town Sheldon Mo. Star R. 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME MARTHA, FRANCIS Fellows

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced MARRIED 1

6. (b) Name of husband or wife W. C. Fellows

6. (c) Age of husband or wife if alive 83 years

7. Birth date of deceased 3 (Month) 27 (Day) 1865 (Year)

8. AGE: Years 77 Months 10 Days 25 If less than one day ..... hr. ..... min.

9. Birthplace Charitan Co. Mo (City, town, or county) 0 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Jack Crutchfield
13. Birthplace Virginia (City, town, or country) 1 (State or foreign country)

MOTHER
14. Maiden name Frances Crutchfield
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Jack Fellows
(b) Address Sheldon Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (Month) 23 (Day) - 1943 (Year)
(c) Place: burial or cremation Brazier Cemetery

18. (a) Signature of funeral director L. B. Beery & Son
(b) Address Sheldon Mo.

19. (a) 1-25-43 (Date received local registrar) (b) Martha Riser (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 1 day 22 year 1943 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from Sept 14 1942 to Jan 22 1943 that I last saw her alive on Jan 20 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia — Duration

Due to

Due to

Other conditions Cardiac decompensation
(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 J. M. Eglestone (M. D. or other) DO.
Address Sheldon Date signed 1-23-43

1119

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 234-200
Date Filed FEB 16 1943

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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. 4203 working under my personal supervision.

Signed Gerald Berry

Licensed Embalmer No. 4203

P. O. Address Sheldon Mo

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

**If this body is not embalmed, fact should be so stated above.**

No. 2B
8-21-41
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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. 5729

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

**1. PLACE OF DEATH:**

(a) County: Barton

(b) City or town: Rural (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) In this community: 2 yrs

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Mo (b) County: Barton

(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: Martha I. Fellows

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex: F

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 ..... years

7. Birth date of deceased: Mch 27 (Month) (Day) 1866 (Year)

8. AGE: Years 77 Months 10 Days 28 If less than one day: ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan Day 29 year 1943 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw him alive on ..... 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia

Due to: Cardiac decompensation (Bronchial pneumonia)

Due to: .....

Other conditions (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)

(b) 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: M. A. Egleston (M. D. or other) DO

Address: Shelby, Mo. Date signed 3-30-43

SUPPLEMENTARY

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