

5-42
17-39
X32873

Registration District No. ~~429~~ 74

Primary Registration District No. ~~429-0657~~

Registrar's No. 53

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town La Russell R.R. #1
(c) Name of hospital or institution: Home Red Oak Trwp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community Active (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence
(c) City or town La Russell R.R. #1
(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 B. Shelton

3. (b) If veteran, name war L 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 Lamira 6. (c) Age of husband or wife if alive 83 years

7. Birth date of deceased 11-14-1856
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 8 13 hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Moses H. Shelton

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

14. Maiden name Mary Chark

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

16. (a) Informant Roy Shelton

(b) Address Mt. Vernon Mo.

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Morris - Lerman

(b) Address Miller Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 27
year 1943 hour 8 minute 15 A. M.

21. I hereby certify that I attended the deceased from 8/22
1943 to 7/15/1943
that I last saw him alive on 7/15/1943
and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxia
Ludwigs Angina
Due to _____
Due to _____

Other conditions Squamous face
(Include pregnancy within 3 months of death)

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 Ferneth Glover (M. D. or other)
Address Exp. Lerman, Mo. Date signed 7/27/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

R. I. ...
District ...
District File ... 943-984
Date ... SEP 7 1943

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 L. B. Seeman
Licensed Embalmer No. 3297
P. O. Address Miller 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *SPD 20*

Registration District No. *176*

Primary Registration District No. *5657*

Registrar's No. *53*

1. PLACE OF DEATH:

(a) County *Lawrence*
(b) City or town *Red Oak, Miss.*
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME *James B. Shelton*

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 *m*

6. (b) Name of husband or wife _____

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

7. Birth date of deceased *Nov. 14 1900*
(Month) (Day) (Year)

8. AGE: Years *86* Months *8* Days _____ If less than one day _____ min.

9. Birthplace *Mo.*
(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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *8-29-43* (b) *Anna Whorney*
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ 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 _____

Duration _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

28643