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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35105

LED NOV 12 1943

State File No. _____

Registration District No. 353

Primary Registration District No. 303-15655

Registrar's No. 169

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town McVernon A.D.C. 3
(c) Name of hospital or institution: X Mt. Vernon Ins.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution X
In this community 1 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence
(c) City or town McVernon (Rural) 055
(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** Medison Sanders Shelton

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased April 20 - 1898
(Month) (Day) (Year)

8. AGE: Years 70 1/2 Months 6 Days 2 If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business Agriculture

12. Name John W. Shelton

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

14. Maiden name Mary B. Cook

15. Birthplace Not known
(City, town, or county) (State or foreign country)

16. (a) Informant Lawrence Shelton

(b) Address McVernon Mo

17. (a) Burial (b) Date thereof 10-24-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation South Bend Cemetery

18. (a) Signature of funeral director Geo. B. Orr

(b) Address McVernon Mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 22nd
year 1943 hour 9 minute 30 a.m.

21. I hereby certify that I attended the deceased from Seen after death only!
that I last saw him alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Failure

Due to Hypertension & Posthypertensive

Other conditions 3a!
(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? _____

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

23. Signature Kenneth Glover (M. D. or other) _____
Address McVernon Mo Date signed 10/27/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1338

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6,

District File Number 1143-1201

Date Filed NOV 2 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 Geo. B. Orr

Licensed Embalmer No. 946

P. O. Address 244 Vernon 7th

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

NOV

State File No.

Registration District No. 283

Primary Registration District No. 5655

Registrar's No.

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town St. Leon R. 0K3
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Leon Hosp
(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)

3. (a) PRINT FULL NAME Gideon S. 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 S

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

7. Birth date of deceased April 20 1878
(Month) (Day) (Year)

8. AGE: Years 70 Months 6 Days 12 If less than one day..... min.

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) (Place: burial or cremation.....)
18. (a) Signature of funeral director..... (b) Address.....
19. (a) 10/25/43 (b) (Dyde Crayford)
(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..... Day..... Year 1943 Hour..... Minute..... M.

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

Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (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?.....

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

23. Signature..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

FILED

35105