

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4629**
Registrar's No. **16**

FILED FEB 23 1944

Registration District No. **4499**

Primary Registration District No. **4499**

1. PLACE OF DEATH:

(a) County **Shelby**
(b) City or town **Shelby**
(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 **60 years**
(Specify whether years, months or days)

3. (a) PRINT **Amanda Laura Ahalt**
FULL NAME

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

4. Sex **M** 5. Color or race **W**
6. (a) Single, widowed, married. **2 divorced Widow**
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive. **1854**
7. Birth date of deceased **June 27 1854**
(Month) (Day) (Year)

8. AGE: Years **89** Months **6** Days **17** If less than one day hr. min.

9. Birthplace **Palmyra MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business

12. Name **Levy Payne**
13. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)
14. Maiden name **Patreola Jones**
15. Birthplace **MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Gladys Ahalt**
(b) Address **Shelby Mo.**

17. (a) (Burial, cremation, or removal) (b) Date thereof **Jan 11 1944**
(Month) (Day) (Year)

(c) Place: burial or cremation **Shelby Mo**

18. (a) Signature of funeral director **Shayer**

(b) Address **Shelby Mo**

19. (a) **Feb 3 44** (b) **Madge L. Smith**
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Shelby**
(c) City or town **Shelby**
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **1-10-44** day
year. hour. minute. M.

21. I hereby certify that I attended the deceased from 19 to 1943
that I last saw her alive on **Aug 1st**
and that death occurred on the date and hour stated above.

Immediate cause of death **Was an invalid for 20 yrs**

Due to **162 lb**

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 **A. M. Wood** (M. D. or other)
Address Date signed **1/13/43**

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

RECEIVED

District Health Officer No. 10

District File Number 2-44-380

Date Filed FEB 8 1944

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.....

E. H. Hayer

Licensed Embalmer No. 1437

P. O. Address.....

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.