

FILED SEP 13 1944

Registration District No. **17**

Primary Registration District No. **4169**

Registrar's No. **223**

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

1. PLACE OF DEATH:

(a) County **DeKalb**

(b) City or town **Osborn** *Colfax*

(c) Name of hospital or institution: **7**

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community **60yr** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **DeKalb 32**

(c) City or town **OSBORN, Mo.** (If outside city or town limits, write "RURAL") **0**

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_ **0**

3. (a) PRINT FULL NAME **Roy Shelton**

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 **Single**

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

7. Birth date of deceased **Sept - 15 - 1881** (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

**62 10 29** hr. min.

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

10. Usual occupation **Decorative Painter**

11. Industry or business **Home Improvement**

MOTHER FATHER { 12. Name **Not known**

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

14. Maiden name **Susan Shelton**

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

16. (a) Informant **Sam Shelton**

(b) Address **Osborn Mo**

17. (a) (b) Date thereof **AUG-18-1944** (Month) (Day) (Year)

(c) Place: burial or cremation **Osborn DeKalb**

18. (a) Signature of funeral director **John H. Clark**

(b) Address **Stewartville Mo**

19. (a) **Aug-17-1944** (Date received local registrar) (b) **John H. Clark** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUGUST** day **14<sup>th</sup>** year **1944** hour **3:20** minute **P** M.

21. I hereby certify that I attended the deceased from **August 10**, 19**44**, to **Aug 17**, 19**44**.

that I last saw him alive on **Aug 17**, 19**44** and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary thrombosis**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) **94a**

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. S. Gale** (M. D. or other) \_\_\_\_\_

Address **Osborn Mo** Date signed **8/14/44**

**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

*F. G. Dixon*

Licensed Embalmer No.

*952*

P. O. Address

*Stewartsville 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.**