

FILED DEC 12 1944

Registration District No. \_\_\_\_\_ Primary Registration District No. **4159** Registrar's No. **102**

1. PLACE OF DEATH: **Daviess**  
 (a) County **Daviess**  
 (b) City or town **Pattonsburg**  
 (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 **1**  
 (Specify whether years, months or days) **about 4 yrs**

2. USUAL RESIDENCE OF DECEASED:  
**Mo Daviess 31**  
 (a) State **Mo** (b) County **Daviess 31**  
 (c) City or town **Pattonsburg, Mo**  
 (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 \_\_\_\_\_

3. (a) PRINT FULL NAME **James Henry Shackelford**  
 3. (b) If veteran, name war **✓**  
 3. (c) Social Security No. **✓**

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **NOV** day **2**  
 year **1944** hour **2** minute **A** M.  
 21. I hereby certify that I attended the deceased from **John Cappel**  
**to Dec 10**, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

4. Sex **M O** 5. Color or race **W**  
 6. (a) Single, widowed, married, divorced **Married**  
 (b) Name of husband or wife **Amelia Shackelford**  
 6. (c) Age of husband or wife if alive **79** years  
 7. Birth date of deceased **Dec 12 - 1869**  
 (Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
 Due to **Coronary Thrombosis**  
 Due to **Senility**  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

8. AGE: Years **84** Months **10** Days **20**  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_  
 9. Birthplace **Harrison Co Mo**  
 (City, town, or county) (State or foreign country)

Major findings:  
 Of operations **94a**  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

10. Usual occupation \_\_\_\_\_  
 11. Industry or business **retired Farmer**  
 MOTHER FATHER { 12. Name **Lewis Shackelford**  
 13. Birthplace **Ind.**  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **not known**  
 15. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)

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? \_\_\_\_\_ (2) Means of injury \_\_\_\_\_

16. (a) Informant **Dr E V Shackelford**  
 (b) Address **St Joseph MO**  
 17. (a) **Burial** (b) Date thereof **11-5-1944**  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Bethany, Mo**  
 18. (e) Signature of funeral director **[Signature]**  
 (b) Address **Pattonsburg Mo**  
 19. (a) **11-15-1944** (b) **[Signature]**  
 (Date received local registrar) (Registrar's signature)

23. Signature **John Staker** (M. D. or other) \_\_\_\_\_  
 Address **Walden, MO** Date signed **12/44**

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

**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. Brown*.....

Licensed Embalmer No. 2857.....

P. O. Address Pattonsburg, 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.**