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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 24 1944
Registration District No. _____

Primary Registration District No. 5413

Registrar's No. 94

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

1. PLACE OF DEATH:

(a) County Douglas

(b) City or town Sweden, Walle
(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 _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Douglas

(c) City or town Sweden Rural
(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 Mary Shelton

3. (b) If veteran, name war _____

3. (c) Social Security No. NO

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 21
year 1944 hour 5 minute 45 P. M.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Wm. J. Shelton

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased February 5, 1894
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 1944 to Sept 15, 1944

that I last saw her alive on Sept 15, 1944
and that death occurred on the date and hour stated above.

8. AGE: Years 50 Months 7 Days 16 If less than one day _____ hr. _____ min.

Immediate cause of death Carcinoma of uterus

Duration 12 mos.

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

Due to _____

Due to Hgb

10. Usual occupation Housewife

Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or business _____

Major findings: Carcinoma of uterus

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name R. G. Simmons

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

14. Maiden name Leona Turner

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

16. (a) Informant Mrs. Shelton

(b) Address Sweden, Missouri

22. If death was due to external causes, fill in the following:

17. (a) Burial (b) Date thereof 9-23-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Loftin

(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? _____

18. (a) Signature of funeral director Clinkingbeard Funeral Home

(b) Address Ava, Missouri

(Specify type of place) _____

(e) Means of injury _____

23. Signature R M Norman (M, D, or other) _____

Address Ava Mo Date signed Sept 27/44

19. 11-1-1944 (Date received local registrar)

(b) Lula Spurlock (Registrar's signature)

1055 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6,

District File Number 1144-1209

Date Filed NOV. 21 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 J. B. Hutchison

Licensed Embalmer No. 3431

P. O. Address Oran, 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.