

S. No. 2
M-3-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 17 1945
Registration District No. _____

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12648**
Registrar's No. **66**

Primary Registration District No. **3000**

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

1. PLACE OF DEATH:
(a) County **Adair**
(b) City or town **Kirksville mo**
(c) Name of hospital or institution: **309 W. Normal**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community **2 weeks**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Adair**
(c) City or town **Kirksville**
(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 **DALTON RAYMOND SHALLEY**
3. (b) If veteran, name war _____
3. (c) Social Security No. **498-12-5195**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Mar** day **10**
year **1945** hour **3 am** minute **30 am**
21. I hereby certify that I attended the deceased from **3/3/1945** to **3/10/1945**
that I last saw him alive on **3/10/1945**
and that death occurred on the date and hour stated above.

4. Sex **M** (1) race **W**
5. Color or _____
6. (a) Single, widowed, married; divorced **M**
6. (b) Name of husband or wife **Lela Shalley**
6. (c) Age of husband or wife if alive **41** years
7. Birth date of deceased: **12-8-1898**
(Month) (Day) (Year)

Immediate cause of death: **myocardial failure (myocarditis)**
Due to **hypertension**
Due to _____

8. AGE: Years **46** Months **3** Days **9**
If less than one day hr. min.

Other conditions: **None**
(Include pregnancy within 3 months of death)
Major findings: **None**

MOTHER FATHER

9. Birthplace **Putnam Co. Mo**
(City, town, or county) (State or foreign country)
10. Usual occupation **auto mechanic**
11. Industry or business **auto**
12. Name **Jacob Shalley**
13. Birthplace **West-Kennett**
(City, town, or county) (State or foreign country)
14. Maiden name **Armeda Palmer**
15. Birthplace **West-Kennett**
(City, town, or county) (State or foreign country)
16. (a) Informant **Lela Shalley**
(b) Address **Kirksville Mo**
17. (a) **Burial** (b) Date thereof **3-12-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Got Creek**
18. (a) Signature of funeral director **Sumner Howell**
(b) Address **Kirksville Mo**
19. (a) **3-13-45** (b) **M. J. Wayner**
(Date received local registrar) (Registrar's signature)

Of operations **None**
Of autopsy **None**
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. J. Wayner** (M-D or other) **DO**
Address **Kirkville Mo** Date signed **3/13/45**

1049

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 4-45-6250

Date Filed APR 13 1945

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 W. C. Summers

Licensed Embalmer No. 2159

P. O. Address Kirkville

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.