V. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUL 21 1945

State File No. 24749

Registration District No. 290 Primary Registration District No. 5986 Registrar's No. 53

1. PLACE OF DEATH:

(a) County Pulaski

(b) City or town Rural — Tavern Twp
(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 years, months or days)
In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pulaski 85

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Cracker Star Rt. #3
(If rural, give location)

(e) Citizen of foreign country? — (Yes or No)

If yes, name country —

3. (a) PRINT FULL NAME NANCY ALICE SHELTON

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Fem. 1

5. Color or race White

6. (a) Single, widowed, married, divorced W. 2

6. (b) Name of husband or wife Joseph Shelton

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

7. Birth date of deceased Sept. (Month) 10 (Day) 1871 (Year)

8. AGE: Years 73 Months 9 Days 6 If less than one day hr. min.

9. Birthplace Cracker, (City, town, or county) Mo (State or foreign country) 11

10. Usual occupation Housekeeper

11. Industry or business Farm

FATHER
12. Name Dan Wall 1
13. Birthplace Tennessee (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Anna Sellars
15. Birthplace Tennessee (City, town, or county) (State or foreign country) 1

16. (a) Informant Orville Shelton
(b) Address Cracker, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-18-45 (Month) (Day) (Year)
(c) Place: burial or cremation Duncan Cem. Cracker, Mo

18. (a) Signature of funeral director C L Casey
(b) Address Iberia Mo

19. (a) 6-22-1945 (Date received local registrar) (b) Chas M Dodd (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16 year 1945 hour 6 minute P M.

21. I hereby certify that I attended the deceased from June 11, 1945, to June 16, 1945; that I last saw her alive on June 16, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage	6 days
Due to arteriosclerosis	years
Due to	
Other conditions: auricular Fibrillation (Include pregnancy within 3 months of death)	years

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Wm. A. Gould (M. D. or other) DO.
Address Iberia Mo Date signed 6/19/45

1170 (Licensed Embalmer's Statement on Reverse Side)

AUG 30 1945

OCT 15 1945

AUG 26 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 C. R. Casey

Licensed Embalmer No. 2694

P. O. Address Iberia 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.