

7. S. No. 2  
00M-2-43  
Rev. 5-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **37633**

**FILED DEC 3 1945**  
Registration District No. 156

Primary Registration District No. 500

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Gasper  
(b) City or town Gasper  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1810 Michigan Ave  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 40 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasper  
(c) City or town Gasper  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1810 Michigan Ave  
(If rural, give location)  
(e) Citizen of foreign country? ( ) (Yes or No)  
If yes, name country \_\_\_\_\_

3. (6) PR John Doak Shelton  
FULL NAME

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced ( )

6. (b) Name of husband or wife MAYME (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 20 1868  
(Month) (Day) (Year)

8. AGE: Years 77 Months 4 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Johnson City, MO  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business Retired Dentist

12. Name Dr. W. E. Shelton

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

14. Maiden name Hodkin

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

16. (a) Informant Mrs. Mayme Shelton  
(b) Address 1810 Michigan

17. (a) Removal to (b) Date thereof 11-22-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place, burial or cremation DW. NEWCOMER, P.M. for CREMATION

18. (a) Signature of funeral director Thornhill Dillon  
(b) Address 305 West 70th St

19. (a) 11-21-45 (b) C. J. Jones  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 21 year 1945 hour 2 minute 30 A.M.  
21. I hereby certify that I attended the deceased from Jan 12 1945 to Nov. 21 1945 that I last saw him alive on Nov. 20 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Nooplaxan of night lung - probably cancer  
Due to \_\_\_\_\_ Duration 10 mos.  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations HND  
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 0

23. Signature Russ L. Huff (M.D. or other) M.D.  
Address Gasper, Mo. Date signed 12/1/45

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

2  
5

1404

45-11-914

---

---

**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 *K. Lynn White*.....

Licensed Embalmer No. *4240*.....

P. O. Address *Joplin, 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.**