

**FILED** DEC 21 1945  
Registration District No. **149** Primary Registration District No. **1002**

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

**1. PLACE OF DEATH:**  
 (a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 6926 Chestnut  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 21 years  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 6926 Chestnut  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** MRS. AMERICA SHELTON  
 3. (b) If veteran, name war No  
 3. (c) Social Security No. None

4. Sex Fe. 5. Color or race White  
 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife John A.  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased unknown  
(Month) (Day) (Year)

**8. AGE:** Years 88 Months \_\_\_\_\_ Days \_\_\_\_\_  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace N. Hartford Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Homemaker

11. Industry or business None

**MOTHER FATHER**  
 12. Name Unknown  
 13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Dora May Rankin  
 (b) Address 6926 Chestnut

17. (a) Removal (b) Date thereof 12/5/45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Chetopa, Kansas

18. (a) Signature of funeral director G. H. Blackman & Son,  
 (b) Address Kansas City, Mo.

19. (a) 12-4-45 (b) Theraldine Holmes  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month 12 day 3  
 year 1945 hour 5 minute 30 P.M.  
 21. I hereby certify that I attended the deceased from March 3  
1944 to Dec. 3 1945  
 that I last saw her alive on Dec 3 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Hypostatic pneumonia  
 Duration 24 hrs.  
 Due to Acute enteritis 2 wks.  
cause unknown  
 Due to Senility

Other conditions 107  
(Include pregnancy within 3 months of death)  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy no

**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? \_\_\_\_\_

23. Signature Earl Wickelma (M. D. or other) h.i.  
 Address 4050 Broadway, KCMo Date signed 12-4-45  
(Specify type of place) (e) Means of injury \_\_\_\_\_

261

4050 Broadway

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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.D. Blackman* .....

Licensed Embalmer No. *3639* .....

P. O. Address..... *R.C. 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.