

5. No. 2  
M-5-43  
5-17-39  
I X36871

State File No. \_\_\_\_\_

**FILED JUN 20 1946**  
Registration District No. 176

Primary Registration District No. 3026

Registrar's No. 169

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Independence  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Independence Sanitarium & Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11 Days  
(Specify whether  
In this community 30 Years  
years, months or days)

3. (a) PRINT FULL NAME JAMES WILLIAM SHACKELFORD

3. (b) If veteran, name war ----- Z 3. (c) Social Security No. -----

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Elizabeth L. Shackelford 6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased May 27, 1869  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>11</u>	<u>22</u>	hr. min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Robert Shackelford

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

14. Maiden name Sarah Mallinix

15. Birthplace No Data  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elizabeth Shackelford

(b) Address Independence, Missouri

17. (a) Burial (b) Date thereof 5/8/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Springs Cemetery

18. (a) Signature of funeral director Poland Spink  
(b) Address Independence, Missouri

19. (a) May 14-1946 (b) James O. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48  
(c) City or town Rural Blue  
(If outside city or town limits, write "RURAL")  
(d) Street No. Spring Branch & Elizabeth St.  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5,  
year 1946 hour 12 minut 15 A. M.

21. I hereby certify that I attended the deceased from Aug 6 1946 to May 5 1946  
that I last saw him alive on May 5 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Valvular heart disease & decompensation and  
Due to Cerebral Cystitis

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations none  
Of autopsy none 354

Duration  
1 yr 0  
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 C. H. Allen M.D. (M.D. or other)  
Address Independence, Mo. Date signed 5-8-46

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

**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 *Poland R. ...*  
..... Licensed Embalmer No. *3604*  
..... P. O. Address *Indy 9th*

**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.**