S. No. 2
M—8-43
. 5-17-39
to I X37823

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

State File No. 33935

FILED OCT 16 1946

Registration District No. 155 Primary Registration District No. ~~XXXX~~ 5579 Registrar's No. 154

1. PLACE OF DEATH:
(a) County: Jasper
(b) City or town: Monroe (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jasper Co T B Hospital 0 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 months (Specify whether years, months or days)
In this community:

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Clay
(c) City or town: Holt (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: Crawford Dean Shackelford
3. (b) If veteran, name war:
3. (c) Social Security No. 500-07-7843

4. Sex: M 0
5. Color or race: Wh
6. (a) Single, widowed, married, divorced: Married 2
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: March (Month) 28 (Day) 1902 (Year)

8. AGE: Years 44 Months 6 Days 7 If less than one day: hr. min.
9. Birthplace: Holt (City, town, or county) Mo (State or foreign country) 0
10. Usual occupation: Mechanic
11. Industry or business:
MOTHER FATHER
12. Name: Robert Shackelford
13. Birthplace: Ky (City, town, or county) (State or foreign country) 1
14. Maiden name: Nellie Crawford
15. Birthplace: Ky (City, town, or county) (State or foreign country) 1
16. (a) Informant: Records
(b) Address:
17. (a) BURIAL XXXXXXXXXX (Burial, cremation, or removal) (b) Date thereof: Oct 7 1946 (Month) (Day) (Year)
(c) Place: burial or cremation: Kearney Mo
18. (a) Signature of funeral director: West City Funeral Co.
(b) Address: West City Mo
19. (a) OCT. 5: 46 (Date received local registrar) (b) J. C. Pritchett M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 5 year 1946 hour 3 minute 35 p M.
21. I hereby certify that I attended the deceased from Sept 23, 1946, to Oct 5, 1946, that I last saw ~~him~~ alive on Oct 5, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis — Duration
Due to:
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings:
Of operations: 1 2 3
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:
(c) 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: 1
23. Signature: Jesse E Douglass (M. D. or ~~Cor.~~)
Address: West City Mo Date signed: 10/5/46

137

(Licensed Embalmer's Statement on Reverse Side)

46-10-864

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 A. K. Mills

Licensed Embalmer No. 347

P. O. Address Nett City 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.