

FILED JAN 9 1947
128
Registration District No. _____

Primary Registration District No. _____

2000

Registrar's No. 1053

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution Springfield Baptist Hospital
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 4 days years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lawrence
(c) City or town Mt Vernon, Rural
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? X (Yes or No)
If yes, name country X

3. (a) PRINT FULL NAME Ray Clark Shelton

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 16 - 1886 (Month) (Day) (Year)

8. AGE: 60 Years 2 Months 13 Days If less than one day _____ hr. _____ min.

9. Birthplace Lawrence Co Mo (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Agriculture & Dairy

12. Name James B Shelton

13. Birthplace Lawrence Co Mo (City, town, or county) (State or foreign country)

14. Maiden name Mrs Boucher

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

16. (a) Informant Eugene Shelton

(b) Address Mt Vernon Mo

17. (a) Removal (b) Date thereof 12-29-46 (Month) (Day) (Year)

(c) Place: burial or cremation Salem

18. (a) Signature of funeral director Geo B Orr

(b) Address Mt Vernon Mo

19. (a) 12-29-46 (b) W E Bradley (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29 year 1946 hour 1:55 minute _____ M.

21. I hereby certify that I attended the deceased from Dec 26, 1946, to Dec 29, 1946, that I last saw him alive on Dec 29, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death Uremia
Due to Chr Glomerular Nephritis
Due to _____

Duration

4 da

Other conditions (Include pregnancy within 3 months of death)

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

23. Signature J. P. Massie (M. D. or other) _____
Address Springfield, Mo Date signed 12/29/46

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

39078

9
2
6

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 George B. Orr

Licensed Embalmer No. 946

P. O. Address W. Vernon

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.