

FILED JUL 30 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25164

Registration District No. 318

Primary Registration District No. 3058

Registrar's No. 120

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montgomery
(c) City or town Soueburg
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Marinelle Shelton

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased June 25 1947
(Month) (Day) (Year)

8. AGE: Years _____ Months 19 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Edgar Myron Shelton

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

14. Maiden name Martha Jane Key

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

16. (a) Informant Edgar Shelton

(b) Address Jonesburg Mo

17. (a) 2 hours (b) Date thereof July 15 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jonesburg Mo

18. (a) Signature of funeral director J.A. Harding

(b) Address Jonesburg Mo

19. (a) 711947 (b) Winnie Hamilton
(Date from local registrar) (Registrar's signature) 011

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14 year 1947 hour 8 minute 32 P. M.

21. I hereby certify that I attended the deceased from 25 June 1947 to 14 July 1947
that I last saw her alive on July 14 1947
and that death occurred on the date and hour stated above.

Immediate cause of death respiratory failure Duration 7

Due to internal hydrocephalus empyema 19 days

Due to stricture of aqueduct of Sylvius

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations 157A Of autopsy internal hydrocephalus - dilation of lateral ventricle

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) (2) Means of injury 0

23. Signature Kottayden (M. D. or other) M.D. Address St. Charles, Mo Date signed 7/18/47

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JUL 29 1947

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. A. Harding

Licensed Embalmer No. 4475

P. O. Address Jonesburg 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.