

S. No. 2  
-12-45  
5-17-39  
PI X47078

FILED OCT 27 1947  
Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
State Hospital No. 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Eyes 2 mos. 8 days  
(Specify whether years, months or days)

In this community 5 years, 2 months, 8 days  
(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. 2105 Prospect Ave.  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country \_\_\_\_\_

PRESTON ELSWORTH SHACKLEFORD

3. (a) PRINT FULL NAME PRESTON SHACKLEFORD

3. (b) If veteran, name war no

3. (c) Social Security No. 494-12-4438

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 18 year 1947 hour 6 minute 20 P. M.

21. I hereby certify that I attended the deceased from 3-1-1943 to 10-18-1947  
that I last saw him live on 10-18-1947  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Negro

6. (a) Single, widowed, married, divorced divorced

6. (b) Name of husband or wife Jennie Lee

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 3-10-1909  
(Month) (Day) (Year)

Immediate cause of death Coronary heart failure Duration 6 weeks

Due to adrenaline, Pericarditis 3 months

Due to \_\_\_\_\_

8. AGE: Years Months Days If less than one day

38 7 8 hr. min.

Other conditions Ptyphoid 6 years  
(Include pregnancy within 3 months of death)

9. Birthplace: Ottolison, Kansas  
(City, town or county) (State or foreign country)

10. Usual occupation Service Worker

Major findings: Of operations g. s. f.

Of autopsy Coronary adhesion, Cardiac - Muscular atrophy.

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

12. Name Preston Shackleford

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

14. Maiden name Loney Bauwling

15. Birthplace Ottolison, Kansas  
(City, town or county) (State or foreign country)

16. (a) Informant Mrs. Jennie Lee Shackleford

(b) Address 2105 Prospect Ave. K.C., Mo.

17. (a) Removal (b) Date thereof 10-22-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ottolison, Kansas

18. (a) Signature of funeral director John H. Alexander

(b) Address 1602 Meador St. J. Mo.

19. (a) 10-21-47 (b) G. C. Jenkins  
(Date received local registrar) (Registrar's signature)

22. If death was due to external cause, 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. H. Warronay (M. D. or other) \_\_\_\_\_

Address State Hospital No. 20 Date signed 10-18-47

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

MOTHER FATHER

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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..... *Wm. H. Alexander* .....

Licensed Embalmer No. 4450 .....

P. O. Address..... St. Joseph, 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.