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FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED JAN 10 1948

Registration District No. 42

MISSOURI DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1000

State File No. 39434

Registrar's No. 1427

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

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: Missouri Methodist Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 weeks  
(Specify whether \_\_\_\_\_)

In this community 60 years.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 729 S. 14th Street  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Laura Frances Shell

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 29th  
year 1948 hour 7 minute 08 P. M.

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife Tolbert Shell

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

7. Birth date of deceased March 31 1864  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct. 15, 1948, to Dec. 29, 1948, that I last saw h. or alive on Dec. 29, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Carcinomatosis Duration 3 mo.

8. AGE: Years 84 Months 8 Days 28  
If less than one day hr. min.

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

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

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

Major findings: - Of operations \_\_\_\_\_

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

10. Usual occupation At home

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Of autopsy Generalized Carcinoma (Microscopic - Not Completed.)

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

12. Name K. F. Moore

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

14. Maiden name Lucretia Robinson

15. Birthplace Unknown Kentucky  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Mrs. Jennie L. Corwin

(b) Address 1419 S. 18th St., St. Joseph, Mo.

17. (a) Burial (b) Date thereof Jan. 3, 1949  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature T. N. Saffstein (M. D. registrar) 20

Address 424 Felia Date signed 12-30-48

18. (a) Signature of funeral director Walter Meierhoffer

(b) Address 1946 Colhoun St., St. Joseph, Mo.

19. (a) 1-6-49 (b) E. G. Jenkins  
(Date received local registrar) (Registrar's signature) 382

St Joseph Mo

JAN 22 1901

JAN 19 1901

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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, \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_,  
working under my personal supervision.

Signed *Raymond H. Horehead*

Licensed Embalmer No. 4413 Missouri

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.**

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:  
(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 (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Laura J. Shell

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

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

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

7. Birth date of deceased March 3 (Month) (Day) (Year)

8. AGE: Years 84 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day) hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER

12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Carcinoma of Head of Pancreas.

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

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

S-39434