

FILED AUG 18 1950

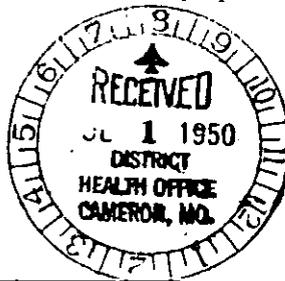
THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26445

BIRTH NO. _____		REG. DIST. NO. <u>98</u>		PRIMARY REG. DIST. NO. <u>5368</u>		Registrar's No. <u>58</u>			
1. PLACE OF DEATH a. COUNTY <u>Davies County</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Davies</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Coffey</u>		c. LENGTH OF STAY (In this place) <u>byr</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Coffey</u>		d. STREET ADDRESS (If rural, give location) <u>None</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>none</u>									
3. NAME OF DECEASED (Type or Print) a. (First) <u>Elsie</u>			b. (Middle) <u>Marie</u>		c. (Last) <u>Shell</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5 - 26 - 50</u>		
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>		8. DATE OF BIRTH <u>January 21, 1912</u>			
9. AGE (In years less birthday) <u>38</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		9. AGE (In years) IF UNDER 1 YEAR Months Days <u>4 5</u>			
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		11. BIRTHPLACE (State or foreign country) <u>0</u>					
13a. FATHER'S NAME <u>John Shell</u>			13b. MOTHER'S MAIDEN NAME <u>Nola Shell</u>			14. NAME OF HUSBAND OR WIFE <u>none</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Nola Shell; Coffey, Missouri</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>virus pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								<u>492x</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>May 24, 1950</u> , to <u>May 26, 1950</u> , that I last saw the deceased alive on <u>May 24, 1950</u> , and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>John Barker M.D.</u> (Degree or title)				23b. ADDRESS <u>Bethany, Mo</u>		23c. DATE SIGNED <u>5/27/50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5-29-1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Miriam</u>		24d. LOCATION (City, town, or county) (State) <u>Bethany, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>30 June 1950</u>		REGISTRAR'S SIGNATURE <u>Vergenia M Engelhardt</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>M B Haas</u>		ADDRESS <u>Bethany Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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



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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed M. B. Haas *M. B. Haas*

Licensed Embalmer No. 3899

P. O. Address Bethany, 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.