

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **14670**

FILED MAY 2 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 450 PRIMARY REG. DIST. NO. 5574 Registrar's No. 92

I. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY OR TOWN <u>Rural Van Buren 2 Wks.</u>	c. LENGTH OF STAY (In this place) <u>2 Wks.</u>	c. CITY OR TOWN <u>Lake Jack</u> <u>7000</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Van. Buren Hosp. 150</u>		d. STREET ADDRESS (If rural, give location) <u>Town</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>MINNIE</u>	b. (Middle) <u>ELLEN</u>	c. (Last) <u>Shelton</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 19 1953</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 13, 1880</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work not during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Higginsville Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Rudolph Scherut</u>	13b. MOTHER'S MAIDEN NAME <u>Mary</u>	14. NAME OF HUSBAND OR WIFE <u>John Shelton</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Neal Lee Helmig</u>	ADDRESS. <u>Lake Jack Mo.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma, gastric</u>		<u>8 mo.</u>
	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>Abscess, of lower quadrant, resulting from perforation</u>			<u>4 mo</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>15 X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)	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 January 10, 1953, to April 19, 1953, that I last saw the deceased alive on 4-19, 1953, and that death occurred at 3:45 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Dr. Shelton MD</u>	(Degree or title) <u>D</u>	23b. ADDRESS <u>Pleasant Hill, Mo</u>	23c. DATE SIGNED <u>4-20-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>4-21-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lake Jack Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Lake Jack Mo.</u>
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DATE REC'D BY LOCAL REG. <u>4-20-53</u>	REGISTRAR'S SIGNATURE <u>W. B. Langford</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Langford</u>	ADDRESS <u>Leds. Summit Mo.</u>
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(Signed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING INK

SEP 30 1953

**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

*B. G. Lindley*

Licensed Embalmer No.

*4892*

P. O. Address

*Leop. Summit*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.