

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20847

LED JUL 2 - 1953

State File No. 259

BIRTH NO. REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. 259

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Poplar Bluff		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural (Richland)	
c. LENGTH OF STAY (in this place)		1030	
d. FULL NAME OF HOSPITAL OR INSTITUTION Poplar Bluff Hospital		d. STREET ADDRESS (If rural, give location) Grayridge, Mo. R.F.D.	

3. NAME OF DECEASED (Type or Print) a. (First) George b. (Middle) Shelton c. (Last) Shelton			4. DATE OF DEATH June 11, 1953 (Month) (Day) (Year)			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Sept. 29, 1942	9. AGE (In years last birthday) 10	10. IF UNDER 1 YEAR 8	11. IF UNDER 10 HRS. 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Victoria, Miss.		12. CITIZEN OF WHAT COUNTRY? U. S.

13a. FATHER'S NAME John Shelton	13b. MOTHER'S MAIDEN NAME Lizzy Johnson	14. NAME OF HUSBAND OR WIFE -----
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S SIGNATURE OR NAME John Shelton, Grayridge, Mo.	ADDRESS
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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) Intestinal Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bacterial enteritis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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 6-10, 1953, to 6-11, 1953, that I last saw the deceased alive on 6-11, 1953, and that death occurred at 7:05 A.M., from the causes and on the date stated above.

23a. SIGNATURE W. H. Strickland, M.D. (Degree or title)	23b. ADDRESS Poplar Bluff, Missouri	23c. DATE SIGNED 6-30-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-14-53	24c. NAME OF CEMETERY OR CREMATORY Dexter Colored	24d. LOCATION (City, town, or county) (State) Dexter, Missouri
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DATE REC'D BY LOCAL REG. 6/26/53	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Strickland-Rainey	ADDRESS Dexter, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

6/29/53

BUTLER CO. HEALTH CENTER

FILE No. _____

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 _____

Licensed Embalmer No. 3479

P. O. Address West, Md

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.