

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7930

State File No.

FILED APR 5 1954

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 90

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If location: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Fulton</u>	c. LENGTH OF STAY (in this place) <u>6 days</u>	c. CITY OR TOWN <u>Fulton</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Callaway Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>17 East 10th St. 0143</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Omer</u> b. (Middle) <u>Alfred</u> c. (Last) <u>Sheley</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 1 1954</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 22, 1883</u>	9. AGE (In years last birthday) <u>71</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Station Agent RR</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Guthrie Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Geo. W. Sheley</u>	13b. MOTHER'S MAIDEN NAME <u>Mattie Ferguson</u>	14. NAME OF HUSBAND OR WIFE <u>Clara Lee Sheley</u>
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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>709 12 0450</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Clara Lee Sheley Fulton 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3-6 months</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia Lung</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>Arteriosclerosis, general</u>		(?) year	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>163X</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
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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?
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22. I hereby certify that I attended the deceased from 11-6-, 1953, to 4-1, 1954, that I last saw the deceased alive on 3-31, 1954, and that death occurred at 9:25 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Andrew S. Lawrence, M.D.</u>	23b. ADDRESS <u>607 East Fulton</u>	23c. DATE SIGNED <u>4-2-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Apr. 2, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Callaway em. Gardens</u>	24d. LOCATION (City, town, or county) (State) <u>Fulton Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Apr 3-1954</u>	REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Margaret ... Fulton Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

APR 16 1957

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.....
Signature of Student Embalmer

Signed.....
J. J. Rossor

Licensed Embalmer No. *25*

P. O. Address *Fullon*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.