

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **43270**

BIRTH NO. _____		REG. DIST. NO. <u>98</u>		PRIMARY REG. DIST. NO. <u>4160</u>		Registrar's No. <u>25</u>	
1. PLACE OF DEATH a. COUNTY <u>Darwin</u> b. CITY OR TOWN <u>Winston</u> c. LENGTH OF STAY (In this place) d. FULL NAME OF HOSPITAL OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>De Kalb</u> c. CITY OR TOWN <u>Weatherby</u> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> e. STREET ADDRESS (If rural, give location) <u>0329</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Elsie</u> b. (Middle) <u>Jane</u> c. (Last) <u>Shelman</u>		4. DATE OF DEATH <u>Dec. 23 - 1955</u> (Month) (Day) (Year)		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED/NEVER MARRIED, WIDOWED/DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>6-28-1880</u>		9. AGE (In years last birthday) <u>75</u>		10. UNDER 1 YEAR: Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Jim McCaskey</u>		13b. MOTHER'S MAIDEN NAME <u>Bayles</u>		14. NAME OF HUSBAND OR WIFE <u>Ray Shelman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Iolita Whitaker - Cameron</u>		ADDRESS <u>mea</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, asthma, etc. It means the disease, injury, or complication which caused death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>suddenly</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>4201</u>	
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 <u>12-23</u> , 19 <u>55</u> to <u>12-23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-23</u> , 19 <u>55</u> , and that death occurred at <u>3: PM.</u> , from the causes and on the date stated above.		23a. SIGNATURE (Degree or title) <u>Fred K. Wilson MD</u>	
23b. ADDRESS <u>Winston Mo</u>		23c. DATE SIGNED <u>1-9-56</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12-26-55</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Christian</u>		24d. LOCATION (City, town, or county) (State) <u>De Kalb Mo</u>		DATE REC'D BY LOCAL REG. <u>1-20-56</u>		REGISTRAR'S SIGNATURE <u>Virginia M Englehart</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Kate Storp</u>		ADDRESS <u>Winston Mo</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

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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, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address .....

**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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.  
If this body is not embalmed, fact should be so stated above.