

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

354

State File No. \_\_\_\_\_

FILED JAN 23 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 41

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Caldwell	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY OR TOWN Polo	d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 15 Min.		e. STREET ADDRESS (If rural, give location) Main St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hosp.			

3. NAME OF DECEASED (Type or Print)	a. (First) NELLIE	b. (Middle) O.	c. (Last) SHELTON	4. DATE OF DEATH (Month) (Day) (Year) Jan. 10, 1956
-------------------------------------	-------------------	----------------	-------------------	---

5. SEX F.	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 7, 1882	9. AGE (In years last birthday) 73	if under 1 year Months _____ Days _____	if under 24 hrs. Hours _____ Min. _____
-----------	------------------------	--	--------------------------------	------------------------------------	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home-Maker	11. BIRTHPLACE (City and State or Foreign Country) Ray Co., Mo.	12. CITIZEN OF WHAT COUNTRY? USA
---	--	---	----------------------------------

13a. FATHER'S NAME Charles W. Dale	13b. MOTHER'S MAIDEN NAME Olivia Magill	14. NAME OF HUSBAND OR WIFE T. M. Shelton
------------------------------------	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME T. M. Shelton	ADDRESS Polo, Mo.
--	------------------------------	---	-------------------

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 3 Hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Burns 90% of Body		
	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.  9160			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 16	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	-------------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Polo Caldwell Missouri
---	---	--

21d. TIME OF INJURY Jan 10 1956 2:30 PM	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Burning Leaves
---	---	---

22. I hereby certify that I attended the deceased from Jan 10, 1956, to Jan 10, 1956, that I last saw the deceased alive on 5:30 PM 1956 and that death occurred at 5:55 P.M., from the causes and on the date stated above.

23a. SIGNATURE [Signature]	(Degree or title) M.D.	23b. ADDRESS ST Joseph Mo	23c. DATE SIGNED 1-10-56
----------------------------	------------------------	---------------------------	--------------------------

24a. BURIAL CREMATION, REMOVAL (Specify) Removal	24b. DATE Jan. 11, 1956	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Polo Mo.
--	-------------------------	------------------------------------	--

DATE REC'D BY LOCAL REG. Jan 17, 1956	REGISTRAR'S SIGNATURE Esther M. Allison 485-D	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Alspaugh & Cowley Mortuary - Polo, Mo.
---------------------------------------	---	---

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.....  
Signature of Student Embalmer

Signed *Charles M. Harman*

Licensed Embalmer No. *448*

P. O. Address *Wetona, W.*

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.