

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **865**

FILED JAN 21 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **116** PRIMARY REG. DIST. NO. **3020** Registrar's No. **52**

1. PLACE OF DEATH a. COUNTY <b>Franklin.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri.</b> b. COUNTY <b>Franklin.</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Washington.</b>	c. LENGTH OF STAY (In this place) <b>37 yrs.</b>	c. CITY OR TOWN <b>Washington.</b>	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 <b>335 High St.</b>		f. STREET ADDRESS (If rural, give location) <b>335 High St. 0362</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Garmon</b> b. (Middle) <b>L.</b> c. (Last) <b>Shelton.</b>	4. DATE OF DEATH <b>Jan. 14th, 1957.</b>
5. SEX <b>Male</b> 6. COLOR OR RACE <b>White.</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 4th, 1891.</b> 9. AGE (In years last birthday) <b>65</b> IF UNDER 1 YEAR Months <b>8</b> Days <b>10</b> IF UNDER 2 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Business.</b>
11. BIRTHPLACE (City and State or Foreign Country) <b>Dixon, Missouri.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>George Shelton.</b>	13b. MOTHER'S MAIDEN NAME <b>Eliza Sooter.</b>	14. NAME OF SPOUSE OR WIFE <b>Ida S. Shelton.</b>
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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) <b>No.</b>	16. SOCIAL SECURITY NO. <b>497-38-2630B</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Ida S. Shelton</b> ADDRESS <b>Washington, Mo.</b>
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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, asthenia, 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) <b>Cerebro-vascular hemorrhage 10 hours</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Bacterial - sclerotic C-V Disease ? years.</b> DUE TO (c) <b>old age</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Blindness</b>			

19a. DATE OF OPERATION <b>none</b>	19b. MAJOR FINDINGS OF OPERATION <b>none</b>	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)
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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 **21 Jan, 1949**, to **13 Jan, 1957**, that I last saw the deceased alive on **13 Jan, 1957** and that death occurred at **5:55 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Raymond J. Boop, M.D.</b>	23b. ADDRESS <b>Washington, Mo.</b>	23c. DATE SIGNED <b>14 Jan 57</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial.</b>	24b. DATE <b>Jan. 16th, 1957.</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery.</b>	24d. LOCATION (City, town, or county) (State) <b>Washington, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>1/15/57</b>	REGISTRAR'S SIGNATURE <b>R. J. Studman for J. J. Studman</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Nielburg &amp; Vitt Inc.</b> ADDRESS <b>Washington, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 23 1957

FEB 27 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. 450 working under my personal supervision..

Student ..... Signature of Student Embalmer

Signed Jerome T. Sevoboda

Licensed Embalmer No. 450

P. O. Address Washington

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.

FBI/1