

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010016

STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 34

FILED APR 7 1959

1. PLACE OF DEATH a. COUNTY Lafayette		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lafayette	
b. CITY OR TOWN Lexington		c. CITY OR TOWN Lexington	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1518 Franklin		d. STREET ADDRESS (If outside, give location) 1518 Franklin	
3. NAME OF DECEASED (Type or print) First James Middle Crawford Last Shelby		4. DATE OF DEATH Month March Day 8 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Dover, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Lynn B. Shelby	
13b. MOTHER'S MAIDEN NAME Lillie Mae Kelly		14. NAME OF HUSBAND OR WIFE Mary Lee Darnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 495-07-2054A	17. INFORMANT Mary L. Shelby, Lexington, Missouri
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Gen'l arteriosclerosis DUE TO (c) 331X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 days 2 years.
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 3/8/59 to 3/8/59 and last saw her/him alive on 2:30 PM on 3/8/59 Death occurred at 4:05 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Ralph W. Arley M.D. (Degree or title)		22b. ADDRESS Lexington, Mo.	
22c. DATE SIGNED 3/30/59		22d. LOCATION (City, town, or county) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 11, 1959	
23c. NAME OF CEMETERY OR CREMATORY Machpelah		23d. LOCATION (City, town, or county) (State) Lexington, Missouri.	
24. FUNERAL DIRECTOR Associates, Lexington, Missouri ADDRESS		25. DATE RECD. BY LOCAL REG. 4-4-59	
26. REGISTRAR'S SIGNATURE Wm. E. Gable		26. REGISTRAR'S SIGNATURE	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Ad

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 *[Handwritten Signature]* _____

. Licensed Embalmer No. *2283*
P. O. Address *[Handwritten 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.