Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-013129
STATE FILE NUMBER

FILED APR 21 1959 Registration District No. 141 Primary Registration District No. 3551 Registrar's No. 43

1. PLACE OF DEATH
a. COUNTY Howell
b. CITY OR TOWN West Plains (If outside corporate limits, give TOWNSHIP only) Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION Rte 3 Length of stay in Hospital Yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Howell
c. CITY OR TOWN West Plains 0460 Inside Limits Yes ☑ No ☑
d. STREET ADDRESS Rte 3 (If outside, give location) Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First James Middle Arthur Last Shelton
4. DATE OF DEATH Month 4 Day 12 Year 1959
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 8-11-1916
9. AGE (In years last birthday) 42 IF UNDER 1 YEAR Months 8 Days 1 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) N. Fork, Mo
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Frank Shelton
13b. MOTHER'S MAIDEN NAME Evelyn May
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. yes
17. INFORMANT Fred Shelton Address West Plains Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Burned to death in home — INTERVAL BETWEEN ONSET AND DEATH 4/12-59 2:00 A.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) House burned, victim overcome
DUE TO (c) by heat & smoke 9160
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 16
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☑ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour 2:00 a.m. Month, Day, Year 4 12 59
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Rte 3
20f. CITY, TOWN, OR LOCATION West Plains COUNTY Howell STATE Mo

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at about 2:00 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Beatrice Cook (Degree or title) Registrar
22b. ADDRESS
22c. DATE SIGNED 4-14-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 4/13-59
23c. NAME OF CEMETERY OR CREMATORY Shepherd Springs
23d. LOCATION (City, town, or county) West Plains (State) Mo

24. FUNERAL DIRECTOR Eberlons ADDRESS West Plains Mo
25. DATE REC'D BY LOCAL REG. 4-14-59
26. REGISTRAR'S SIGNATURE Beatrice Cook

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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.