

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

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FILED VS JAN - 8 1960

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 5647 Registrar's No. 145

MEMORIALIZED

|   |   |  |  |   |   |  |                |
|---|---|--|--|---|---|--|----------------|
| 1. PLACE OF DEATH   |   |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |   |  |                |
| a. COUNTY <b>LAWRENCE</b>   |   | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>FREISTATT</b>   |  | a. STATE <b>MO.</b>   |   | b. COUNTY <b>BARRY</b>   |                |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MAIN STREET</b>  |   | Length of stay in lb <b>2 wks</b>  |  | c. CITY OR TOWN <b>FLAT CREEK TWP.</b>  |   | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |                |
|   |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  | d. STREET ADDRESS <b>2 mi. North Cassville</b>  |   | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |                |
| 3. NAME OF DECEASED (Type or print)   |   |  |  | 4. DATE OF DEATH  |   |  |                |
| First <b>MATHEW</b>   |   | Middle <b>HUSTON</b>   |  | Last <b>SHELTON</b>   |   | Month <b>Dec.</b> Day <b>29</b> Year <b>1959</b>                                   |                |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>W</b>   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>7-15-78</b>                  | 9. AGE (last birthday) <b>81</b>  | IF UNDER 1 YEAR   |  | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telegraph operator</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Oil Company</b>   |  | 11. BIRTHPLACE (City and state or country) <b>Crocker, Missouri</b>                   |   | 12. CITIZEN OF WHAT COUNTRY <b>USA</b>   |                |
| 13a. FATHER'S NAME <b>Charles N. Shelton</b>  |   |  | 13b. MOTHER'S MAIDEN NAME <b>Carloine Madden</b> |   | 14. NAME OF HUSBAND OR WIFE <b>Alma M. (Sears) Shelton</b>  |  |                |
| 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>none</b>  |  | 17. INFORMANT <b>C. Newton Shelton, Freistatt, Mo.</b>                                |   |  |                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |   |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH   |                |
| IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>  |   |  |  |   |   | <b>10 min.</b>   |                |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____   |   |  |  |   |   |  |                |
| DUE TO (c) _____  |   |  |  |   |   |  |                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |   |  |  |   | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |                |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 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 _____ a.m. _____ p.m.  | Month, Day, Year _____   |  |   |   |  |                |
| 20d. INJURY OCCURRED WHILE AT WORK <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 <b>8-6-59</b> to <b>11-18-59</b> and last saw her/him alive on <b>11-18-59</b> . Death occurred at <b>8:00 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |  |   |   |  |                |
| 22a. SIGNATURE <b>Charles Price MD</b> (Degree or title)  |   |  |  | 22b. ADDRESS <b>Cassville, Mo.</b>  |   | 22c. DATE SIGNED <b>12-31-59</b>   |                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 23b. DATE <b>1-2-60</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>  |  | 23d. LOCATION (City, town, or county) <b>Cassville, Missouri</b>                      |   | (State)  |                |
| 24. FUNERAL DIRECTOR <b>Poyle E. Williamson, Cassville, Mo.</b>   |   |  | 25. DATE REGD. BY LOCAL REG. <b>1-5-1960</b>     |   | 26. REGISTRAR'S SIGNATURE <b>HW Fossett</b>   |  |                |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Dry E. Wilborn

Licensed Embalmer No. 4883

P. O. Address Cassville, Mo.

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.