

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 16 1960

2 **60-011838**

Registration District No. 215 Primary Registration District No. 4327 Registrar's No. 4327 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Miller</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> <u>Miller</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Iberia</u>		Length of stay in 1b <u> yrs</u>	c. CITY OR TOWN <u>Iberia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Home</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Alvia</u> Middle <u>—</u> Last <u>Shelton</u>	4. DATE OF DEATH Month <u>Feb</u> Day <u>20</u> Year <u>1960</u>
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5. SEX <u>ab</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/17/1889</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Hawkeye Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>John Shelton</u>	13b. MOTHER'S MAIDEN NAME <u>Mary McDowell</u>	14. NAME OF HUSBAND OR WIFE <u>Pearl Shelton</u>
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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) <u>yes</u> <u>W.W.I</u>	16. SOCIAL SECURITY NO. <u>499031442</u>	17. INFORMANT <u>Pearl Shelton, Iberia, Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cardio-Vascular - Renal Disease</u>	<u>2 yrs.</u>
	DUE TO (c) <u> </u>	

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
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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.)
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u>

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Iberia</u>	COUNTY <u> </u>	STATE <u> </u>
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21. I attended the deceased from 1950 to Feb 20, 1960 and last saw her/him alive on Feb 20, 1960.
Death occurred at 3:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W.M.A. Gould D.D.</u>	22b. ADDRESS <u>Iberia Mo</u>	22c. DATE SIGNED <u>2/23/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>2/23/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Iberia</u>	23d. LOCATION (City, town, or county) <u>Iberia, Mo</u>	(State) <u> </u>
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24. FUNERAL DIRECTOR <u>Edges Funeral Homes Iberia, Mo.</u>	ADDRESS <u> </u>	25. DATE RECD. BY LOCAL REG. <u>Feb. 25 1960</u>	26. REGISTRAR'S SIGNATURE <u>Jessie Perkins</u>
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(Licensed Embalmer's Statement on Reverse Side)

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
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.