

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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FILED VS. JUN 20 1960

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STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>10 years</b>	c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>615 No. 9th St.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>615 No. 9th St./</b>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>L</b> Last <b>SHELBY</b>			4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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>9-23-1902</b>	9. AGE (last birthday) <b>57 yrs/</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mitchell-Hill Seed Co.</b>	11. BIRTHPLACE (City and state or country) <b>Albany, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Everett Shelby</b>		13b. MOTHER'S MAIDEN NAME <b>Dollie Robertson</b>		14. NAME OF HUSBAND OR WIFE <b>Thelma Shelby (deceased)</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>488-14-0860</b>	17. INFORMANT <b>Mrs. W. B. Walker, St. Joseph, Mo</b>	Address <b>615 No. 9th St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra cranial hemorrhage (8cm)</b> DUE TO (b) <b>Intra cranial fracture</b> DUE TO (c) <b>Fall</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 days</b> <b>2 1/2 days</b>
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 checked="" 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.) <b>Fell striking head.</b>			
20c. TIME OF INJURY <b>9:40 a.m.</b>	Month, Day, Year <b>6-10-60</b>				
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.) <b>Between 2nd &amp; 3rd, on Felix Street</b>	20f. CITY, TOWN, OR LOCATION <b>St. Joseph,</b>	COUNTY <b>Buchanan,</b>	STATE <b>Missouri</b>	
21. I attended the deceased from <b>Grandview Hosp</b> , to <b>one a</b> and last saw him alive on <b>6-13-60</b> Death occurred at <b>one a</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>S.E. Melaney MD</b> (Degree or title) <b>Coroner</b>		22b. ADDRESS <b>714 Kirkpatrick St. Jax Mo</b>	22c. DATE SIGNED <b>6-13-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6-14-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grandview Cemetery</b>	23d. LOCATION (City, town, or county) <b>Albany,</b>	STATE <b>Missouri</b>	
24. FUNERAL DIRECTOR <b>Brooks + Cochell Sun Home</b>		ADDRESS <b>Albany, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>June 15, 1960</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>	

DOCUMENT

S.E. Melaney MD 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 Charles E. Bennett

Licensed Embalmer No. 4677

P.O. Address St. Joseph

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.