

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037340

STATE FILE NUMBER

AMENDED

Registration District No. 150 Primary Registration District No. 4241 Registrar's No. 90

FILED NOV 14 1961

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Oak Grove</u>		Length of stay in lb <u>50 yrs</u>	c. CITY OR TOWN <u>Oak Grove</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 TOWN</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>none TOWN</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>T</u> Last <u>Shelby</u>	4. DATE OF DEATH Month <u>November</u> Day <u>2</u> Year <u>1961</u>
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5. SEX <u>male</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>Mar. 27-1887</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automobile Dealer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>	11. BIRTHPLACE (City and state or country) <u>Lexington, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>
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13a. FATHER'S NAME <u>Joseph Shelby</u>	13b. MOTHER'S MAIDEN NAME <u>Kate L. Shelby</u>	14. NAME OF HUSBAND OR WIFE <u>Jesse Shelby</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>no</u>	17. INFORMANT <u>Carl T. Shelby, Jr. Oak Grove 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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Murder</u>		<u>5 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cancer of bladder with</u>	<u>12 mo.</u>
	DUE TO (c) <u>neurovascular metastases</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 _____ 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 _____
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21. I attended the deceased from <u>12 months prior</u> to <u>Nov. 2 1961</u> and last saw her/him alive on <u>Nov. 2, 1961</u> Death occurred at <u>5:49 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>O. L. Luster MD</u> (Degree or Title)	22b. ADDRESS <u>Oak Grove Mo</u>	22c. DATE SIGNED <u>11-3-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 4, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>McFirlan Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Lexington, Missouri</u>
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24. FUNERAL DIRECTOR <u>Hopper-Royer Funeral Home</u>	ADDRESS <u>Oak Grove, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>11-4-61</u>	26. REGISTRAR'S SIGNATURE <u>W. B. Langeford</u>
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DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
ITEM NO.
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 *Kenneth Ray*

Licensed Embalmer No. 4591

P. O. Address Oak Grove

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.