S. No. 2
DM—2-43
v. 5-17-39
I X35897

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 5 1947

Registration District No. 1

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23256

Primary Registration District No. 2008

Registrar's No. 203

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville, Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Adair
(c) City or town Kirksville
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Lettie A. Sholley
3. (b) If veteran, name war
3. (c) Social Security No. None
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Albert W. Sholley
6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased December (Month) 7 (Day) 1885 (Year)

8. AGE: Years 61 Months 7 Days 14 If less than one day hr. min.

9. Birthplace Elvaston (City, town, or county) Illinois (State or foreign country)
10. Usual occupation Housewife
11. Industry or business Home
FATHER
12. Name William Ogle
13. Birthplace State of Ohio (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Albert W. Sholley
(b) Address Kirksville, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/47 (Month) (Day) (Year)
(c) Place: burial or cremation Forest Cemetery
18. (a) Signature of funeral director D. E. Riley
(b) Address Kirksville, Missouri
19. (a) 7-29-47 (Date received local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21 year 1947 hour 12:40 minute P: M.

21. I hereby certify that I attended the deceased from July 20, 1947 to July 21, 1947 that I last saw her alive on July 20, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature C. T. Rhoads (M. D. or other) D.O.
Address Kirksville, Mo Date signed 7-22-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 8:47:979
AUG - 4 1947
Date Filed

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.....

Kenneth Slavens, Registered Apprentice No. 418,

working under my personal supervision.

Signed Dee Riley

Licensed Embalmer No. 4181

P. O. Address Kirksville, 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 this body is not embalmed, fact should be so stated above.