

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032124

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 296 Primary Registration District No. 6018 Registrar's No. 5

FILED SEP 10 1962

VS 300  
Rev. 4/59

1 0890  
2 0890

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4 0  
5 1  
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12 90-0  
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Ray</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Ray</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fishing River Twp.</b>		Length of stay in lb <b>Lifetime</b>	c. CITY OR TOWN <b>Rayville</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5 miles E. Excelsior Springs</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5 miles SW Rayville</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Fred Shelton</b>			4. DATE OF DEATH Month Day Year <b>Aug. 19, 1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-10-1893</b>
9. AGE (last birthday) <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer and Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming and Building</b>	11. BIRTHPLACE (City and state or country) <b>Ray County, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Francis Shelton</b>	
13b. MOTHER'S MAIDEN NAME <b>Martha Searcy</b>		14. NAME OF HUSBAND OR WIFE <b>Allie M. Shelton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>194-20-7890</b>	17. INFORMANT <b>Allie M. Shelton, Rayville, Missouri</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>Coronary occlusion</b>			<b>instant</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>coronary heart disease</b>			<b>sev. mos.</b>
DUE TO (c) <b>arteriosclerosis</b>			<b>sev. years</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 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>Aug. 19, 1962</b> and last saw him alive on <b>August 19, 1962</b> Death occurred at <b>8:30 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title) <b>M. D.</b>		22b. ADDRESS <b>Excelsior Springs, Mo.</b>	22c. DATE SIGNED <b>9/1/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>8-19-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pisgah</b>	23d. LOCATION (City, town, or county) (State) <b>Rural, Excelsior Springs, Mo.</b>
24. FUNERAL DIRECTOR <b>Prichard Funeral Home, Inc.</b> <b>Excelsior Springs, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>9-3-62</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

USE BLACK INK OR TYPEWRITER RIBBON

MS SEP 13 1962

Permit not obtained 9-6/62  
W. J. S.

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 Louise Garrison

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs 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.