

REC'D APR 11 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

10271
Do not use this space.

1. PLACE OF DEATH 3

(a) County Callaway Registration District No. 104

(b) Township Fulton Primary Registration District No. 3008 Registered No. 82

(c) City Fulton (d) Street No. State Hospital #1 St.

(e) Length of residence in city or town where death occurred yrs. mos. 28 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William L. Shelton

(a) Residence, No. Road 1 (R. R. #2) Mo. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Josephine Shelton

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 7th 1876

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

62 62 10 14

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Blacksmith

9. Industry or business in which work was done, as saw mill, bank, etc. Blacksmith

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER

13. NAME George Shelton

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER

15. MAIDEN NAME Sarah Mitchell

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) State Hospital #1 records

18. BURIAL, CREMATION, OR REMOVAL PLACE To a nso DATE 23rd Mar 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Robt Murray

20. FILED Mar. 20, 1939 A. N. Crease Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 20th 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb. 22nd 1939 to Mar 20th 1939

I last saw h. alive on Mar 19, 1939 Death is said to have occurred on the date stated above, at 12:05 p.m.

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis. 99

Other contributory causes of importance: Psychosis with cerebral degeneration, Hypostatic pneumonia, Cathelexia (general)

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? No Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____ (Signed) J. J. Wood M. D.

(Address) State Hospital #1 Fulton

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

14
11
11

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.....

....., Registered Apprentice No.....

working under my personal supervision.

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 this body is not embalmed, above space should be left blank.