

FILED JUL 15 1940

No. 2
11-10-39
5-17-39
1 X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

21791

State File No. _____

Registration District No. ~~324~~ 324

Primary Registration District No. 5-449

Registrar's No. _____

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Robberson, Mo. Springfield WILLARD.
(c) Name of hospital or institution: R # 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution in his home
In this community 60 yr. - 5 mo. - 7 da. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene
(c) City or town Willard. (If outside city or town limits, write "RURAL")
(d) Street No. R # 2 (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME HARLES C. SHELEDY

3. (b) If veteran, name war _____ 3. (c) Social Security No. #

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Ethel Shelledy 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 19 - 1880
(Month) (Day) (Year)

8. AGE: Years 60 Months 5 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Greene Co. Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business On Farm

12. Name Leander Shelledy

13. Birthplace Ill.
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Calhoun

15. Birthplace Ind.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ethel Shelledy
(b) Address Willard Mo. R # 2

17. (a) Burial (b) Date thereof June 30 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Robberson Prairie

18. (a) Signature of funeral director J. W. Klingner & Co.
(b) Address Springfield Mo.

19. (a) June 29 1940 (b) Mrs. Guy Freeman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26
year 1940 hour 11 minute 55 P. M.

21. I hereby certify that I attended the deceased from 6/27 - 40
6/27, 1940 to 6/27, 1940
that I last saw him alive on June 2, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cornavirus Embolus

Due to C

Due to 94 B

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: none
Of operations none
Of autopsy none

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence none

(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature D. F. Freeman (M. D. or other)
Address Springfield (Specify type of place)
Date signed 7/27/40 (a) Means of injury none

Duration
3 hrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

RECEIVED

Greene County Health Office,

County File Number 40-7-37

Date Filed 7-10-40

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 J. B. King

Licensed Embalmer No. 3358

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.