

DEC 16 1940
Registration District No. **744**

Primary Registration District No. **59766**

Registrar's No. **110**

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

1. PLACE OF DEATH:
(a) County Richmond, Mo. (Ray Co.)
(b) City or town Rural (Richmond Twp)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(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 all life years, months or days) 2

3. (a) PRINT FULL NAME Jeanette June Shelton
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Child
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Apr. 26/38 - 1938
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>2</u>	<u>08</u>	<u>23</u>	hr. _____ min _____

9. Birthplace Ray County, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____

MOTHER FATHER
12. Name Estil Shelton
13. Birthplace Ray County, Mo. (City, town, or county) (State or foreign country)
14. Maiden name Madaline O'Dell
15. Birthplace Rayville, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Estil Shelton
(b) Address Richmond, Mo.

17. (a) ~~City or town~~ (b) Date thereof 11/19/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Crowley Cem.

18. (a) Signature of funeral director J. H. Brothers
(b) Address Richmond, Mo.

19. (a) Nov 20 40 (b) Malcolm Jackson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Ray
(c) City or town Richmond, Mo. (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. U.S.A. years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 18
year 1940 hour 11 minute 15 A. M.
21. I hereby certify that I attended the deceased from Nov. 18
1940, to Nov 19, 1940
that I last saw her alive on Nov 18, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral Tubercular Pneumonia ✓
Duration 1 day

Due to _____
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? _____

965 (Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature J. W. Gaines M.D. (M. D. or other) J. M. D.
Address Richmond, Mo. Date signed 11-19-40

1092

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-12-40

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

J.B. Brothers

Registered Apprentice No.

working under my personal supervision.

Brothers funeral home

Signed

J.B. Brothers

Licensed Embalmer No. 2001

P. O. Address Richmond, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 395-77
Registrar's No. 110

Registration District No. 744

Primary Registration District No. 5976 B

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

1. PLACE OF DEATH:
 (a) County: Madison Ray
 (b) City or town: Richmond T.O.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community _____ years, months or days)

3. (a) PRINT FULL NAME Jeannette Jane Shelton
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Child
 6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
 7. Birth date of deceased (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 2 Months 6 Days 23 If less than one day _____ min.

9. Birthplace (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____ (If outside city or town limits write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH Month 7 day 18 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral lobar pneumonia Duration _____

Due to No complications or cause known

Due to _____

Other conditions (Include pregnancy within 3 months of death) 107W

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? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature GW Gaynes md (M. D. or other)

Address Richmond, Mo. Date signed 1-29-41

SUPPLEMENTAL

1940

S-39577