

1 FEB 1 10 1941
Registration District No. 67

Primary Registration District No. 51020

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Bollinger
(b) City or town Rural, L. L. Vance
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 4 mi. S.E. of Rutesville Mo.
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Bollinger
(c) City or town 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.? _____ years.

3. (a) PRINT FULL NAME Arminia Shelton

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

4. Sex fm 5. Color or race W 6. (a) Single, widowed, married, divorced, widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased July 23 1854
(Month) (Day) (Year)

8. AGE: Years 86 Months 05 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation house wife

11. Industry or business _____

MOTHER FATHER { 12. Name Kalab Eaker
13. Birthplace _____ (City, town, or county) (State or foreign country) V. O.
14. Maiden name Ebbie Shelton
15. Birthplace _____ (City, town, or county) (State or foreign country) V. O.

16. (a) Informant's own signature _____ (b) Address Rutesville Mo.

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation Dry Creek Cemetery

18. (a) Signature of funeral director R. E. Drum

(b) Address Rutesville

19. (a) 1-20-1941 (b) Mrs. Henry Allen
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 9/12/38 to 1/15/41, 19____; that I last saw him alive on 1/15/41, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to Influenza

Due to 93 W

Other conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings: _____ Of operations _____

Of autopsy _____

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 John J. Myrtle (M. D. or other) _____
Address Rutesville Date signed 1/12/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

1941 1 X19811

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 Glenn Wilson

Licensed Embalmer No. 7878

P. O. Address Jackson 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 1706

Registration District No. 64

Primary Registration District No. 5102C

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Bollinger

(b) City or town Osance Twp
(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 Armintha Shelton

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

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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	Months	Days	If less than one day
	<u>86</u>	<u>5</u>	<u>9</u>	hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business _____

12. Name Kalob Shelton

13. Birthplace Not Known
(City, town, or county) (State or foreign country)

14. Maiden name Iris Shelton

15. Birthplace Not Known
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) Mar 31-1941 (b) Mrs Henry Illers
(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.

20. DATE OF DEATH: Month JANUARY day 16
year 1941 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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 John J. Myers (M-D or other) _____
Address Antlers Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

S-1706