

No. 11-10...
1-17-39
1 X 2 1/2

Registration District No. **488**

Primary Registration District No. **62365**

Registrar's No. **4**

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

1. PLACE OF DEATH:

(a) County Lincoln (b) City or town Siles Mo. 2.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rural
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)

In this community Allegra

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lincoln

(c) City or town Siles Mo. Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME John E. Shelker

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

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

6. (b) Name of husband or wife Elizabeth Shelker 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased April 5 1862
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>11</u>	<u>24</u>	hr. _____ min. _____

9. Birthplace Hawk Point Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry of business _____

MOTHER FATHER

12. Name Joseph P. Shelker

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

14. Maiden name Ida Dargatzis

15. Birthplace Hawk Point Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elizabeth Shelker

(b) Address Siles Mo.

17. (a) Burial (b) Date thereof 3-30-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hawk Point Cem.

18. (a) Signature of funeral director W.R. Womms

(b) Address Siles Missouri

19. (a) 3-29-1941 (b) W.F. Quinn
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29
year 1941 hour 12 minute 30 A.M.

21. I hereby certify that I attended the deceased from March 28, 1941, to March 29, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Artero-Sclerosis

Due to _____

Due to _____

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

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy None

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 O.H. Dawson (M. D. or _____)

Address Siles Mo. Date signed 3-29-41

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~~ W. R. Hammer

....., Registered Apprentice No.
working under my personal supervision.

Signed W. R. Hammer

1-02-6 Licensed Embalmer No. 2251

P. O. Address Sibley 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.

No. 2
-1-4-41
-17-39
X-28350

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11230

Registration District No. 488

Primary Registration District No. 6365

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Linn
- (b) City or town Haskell Point 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

John E Shelker

- 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 M

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

7. Birth date of deceased Apr 5 1868
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>11</u>	<u>24</u>	hr. _____

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

10. Usual occupation _____

11. Industry or business _____

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) 6-7-41 (b) W. F. Quinn
(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) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 29
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred _____ on the date and hour stated above.

Immediate cause of death _____ Duration _____

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? _____

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

23. Signature O. H. Damron (M. D. or other) _____

Address Siles Mo. Date signed _____

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

SUPPLEMENTARY

1941
S-11230

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, fact should be so stated above.