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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN - 6 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

40829

State File No.

Registration District No. 1302 Primary Registration District No. 4204 Registrar's No.

1. PLACE OF DEATH:
(a) County Grundy
(b) City or town Laredo
(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 years, months or days) In this community Life time.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Grundy 40
(c) City or town Laredo. 0
(If outside city or town limits, write "RURAL") 0
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3. (a) PRINT FULL NAME CLEMENTINE BELSHE
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased November (Month) 14 (Day) 1848 (Year)

8. AGE: Years 94 Months 1 Days 12 If less than one day hr. min.

9. Birthplace Laredo, Grundy - Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name James Kilburn
13. Birthplace Ky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sarah Thompson
15. Birthplace Ky (City, town, or county) (State or foreign country)

16. (a) Informant Amelia Tracy
(b) Address Laredo Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-1942 (Month) (Day) (Year)
(c) Place: burial or cremation Stucker Cemetery
18. (a) Signature of funeral director. E. J. Robertson
(b) Address Laredo, Mo.
19. (a) 12-28-42 (Date received local registrar) (b) Nada Hoffman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 26 year 1942 hour Seven minute 30 A.M.
21. I hereby certify that I attended the deceased from December 22nd, 1942, to Dec. 26, 1942 that I last saw her alive on Dec. 25th, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Heart Failure With Arteriosclerosis. | Duration

Due to Old age

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: B. Lee Shelhorse, DO

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

23. Signature B. Lee Shelhorse (M.D. or other)
Address Laredo, Missouri Date signed Dec. 28, 1942

1202 (Licensed Embalmer's Statement on Reverse Side)

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. E. J. Robertson

Licensed Embalmer No. 7468

P. O. Address. Laredo, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40829

Registration District No. 132 Primary Registration District No. 7204 Registrar's No.

1. PLACE OF DEATH:
(a) County Grundy
(b) City or town Laredo
(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 years, months or days)
In this community life

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Grundy
(c) City or town Laredo
(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

3. (a) PRINT FULL NAME Clementine Belshe
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 wd
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov 14 — 1848 (Month) (Day) (Year)
8. AGE: Years 94 Months 1 Days If less than one day hr. min.
9. Birthplace Mo (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name James Kilburn
13. Birthplace Ky (City, town, or county) (State or foreign country)
14. Maiden name Sarah Thompson
15. Birthplace Ky (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 26 year 1942 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.

	Duration
Immediate cause of death Heart failure due to	—
Chronic Myocarditis	
Due to arterio sclerosis	
Due to	
Other conditions (Include pregnancy within 3 months of death) 930	
Major findings: Of operations	PHYSICIAN
Of autopsy	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)
(b) 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 D. Lee Shelhorse (M.D. or other) D.O.
Address Box No 177, Laredo, Mo. Date signed

SUPPLEMENTARY