S. No. 2
DM—3
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 27 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16346

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 373

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Springfield Baptist Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 28 da. (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Wright 114

(c) City or town Norwood 0
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Della Shelton

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race Wht.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Marion A. Shelton

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased Feb. 1, 1888 (Month) (Day) (Year)

8. AGE: Years 58 Months 3 Days 0 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Henry Coday

13. Birthplace Wright Co. (City, town, or county) Mo. (State or foreign country) 0

14. Maiden name Eliza Jane Boyd

15. Birthplace Wright Co. (City, town, or county) Mo. (State or foreign country) 0

16. (a) Informant Haden Coday Bro.

(b) Address 1506 Maryland Springfield, Mo.

17. (a) Mansfield, Mo. (Burial, cremation, or removal) (b) Date thereof 5-3-46 (Month) (Day) (Year)

(c) Place: burial or cremation Mansfield, Mo.

18. (a) Signature of funeral director Thomas J. Handley

(b) Address Norwood, Mo.

19. (a) 5-3-46 (Date received local registrar) (b) D. W. G. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1 year 1946 hour 10 minute 50 A.M.

21. I hereby certify that I attended the deceased from Dec 30, 1945 to May 1, 1946 that I last saw her alive on May 1, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Septicaemia	17 da
Due to: Carcinoma of Uterus	
Due to: Multiple fibroids of uterus with degeneration	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operation: Fibroids of uterus with degeneration
Of autopsy: 48 hr

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 Robert Glynn (M. D. or other)

Address Springfield, Mo. Date signed 5/7/46

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(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 Thomas G. Houldin

Licensed Embalmer No. 4317

P. O. Address Norwood, 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.