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DEPARTMENT OF COMMERCE
 BUREAU OF THE Census
 THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **16844**
 Registrar's No. **2048**

FILED MAY 16 1946
 Registration District No. **149**

Primary Registration District No. **1002**

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

15726

1. PLACE OF DEATH:
 (a) County **JACKSON**
 (b) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **ST. MARY'S HOSPITAL 0**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **10 DAYS**
(Specify whether years, months or days)
 In this community **25 YEARS**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MISSOURI** (b) County **JACKSON**
 (c) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL")
 (d) Street No. **2935 LOCKRIDGE AVENUE**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No?)
 If yes, name country _____

3. (a) PRINT FULL NAME **MR. RAYMOND SCOTT SHELLEY**
 3. (b) If veteran, name war **WORLD WAR II**
 3. (c) Social Security No. **492-14-3240**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **MAY** day **2ND**
 year **1946** hour **5** minute **45A** M.
 21. I hereby certify that I attended the deceased from **April 24**
 19**46**, to **May 2**, 19**46**
 that I last saw him alive on **May 1**, 19**46**
 and that death occurred on the date and hour stated above.

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**
 6. (b) Name of husband or wife **MRS. MANOLA SHELLEY** 6. (c) Age of husband or wife if alive **26** years
 7. Birth date of deceased **JANUARY 18 1921**
(Month) (Day) (Year)

Immediate cause of death **acute monocytic leukemia**
 Due to _____
 Due to _____
 Other conditions **74a**
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy **see above**

8. AGE: Years Months Days If less than one day
25 3 15 14 hr. min.

9. Birthplace **KANSAS CITY MISSOURI**
(City, town, or county) (State or foreign country)
 10. Usual occupation **ELECTRICIAN**

11. Industry or business **WACHTER ELECTRIC COMPANY**
 12. Name **EARL SHELLEY**
 13. Birthplace **BARCLAY KANSAS**
(City, town, or county) (State or foreign country)
 14. Maiden name **SUSAN BURKHOLDER**
 15. Birthplace **ELDORADO KANSAS**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Manola Shelley**
 (b) Address **2935 Lockridge Avenue**
 17. (a) **BURIAL** (b) Date thereof **May 4, 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Dorest Hill**

18. (c) Signature of funeral director **D. K. Newcomer**
 (b) Address **1401 BRUSH CREEK BLYD**
 19. (a) **5-4-46** (b) **Alma Holme**
(Date received local registrar) (Registrar's signature)

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)
 (c) Means of injury _____
 23. Signature **Herb H. Hough** (M. D. or other) **M.D.**
 Address **618 May 1946** Date signed **May 3 1946**

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

618 Professional Bldg
1-5

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. Oscar Hestley
Licensed Embalmer No. 1767
P. O. Address Kansas City

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.