

State File No. _____
 Registrar's No. 281

Registration District No. 146 Primary Registration District No. 5568

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Rural Intercity
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 8728 Winner Rd. Kansas City, Mo!
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution no (Specify whether years, months or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Jackson
 (c) City or town Inter City
(If outside city or town limits, write "RURAL" and name of township)
 (d) Street No. 8728 Winner Rd. Kansas City, Mo!
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Bessie May Shelton
 3. (b) If veteran, name war no
 3. (c) Social Security No. no

4. Sex Fem / 5. Color or race Wh
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Millard Shelton
 6. (c) Age of husband or wife if alive 47 years
 7. Birth date of deceased 1/10/1910
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
36 6 28 hr. min.

9. Birthplace Mt. Erie, Ill
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business //

12. Name Jacob Travers

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

14. Maiden name Carrie Davis

15. Birthplace Ill
(City, town, or county) (State or foreign country)

16. (a) Informant Millard Shelton

(b) Address 8728 Winner Rd.

17. (a) Burial (b) Date thereof 8/12/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director John P. Shell

(b) Address K. C. Mo.

19. (a) 8-14-46 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 8
 year 1946 hour 4.05 A minute A M.

21. I hereby certify that I attended the deceased from 2 hrs to 46 days
 that I last saw 2 alive on 46 days, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis
 Due to _____

Due to _____
 Other conditions HB
(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 [Signature] (M. D. or other)
 Address _____ Date signed 8/12/46

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

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

25432

Dr. Fred Hink,
10235 Indep. Ave.,
After 2.30 P M

Take to City Hall in Independence

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.....

John P. Sheik

Licensed Embalmer No. 3625

P. O. Address. No 6 No

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.