

No. 2
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5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10461**
Registrar's No. **88**

FILED APR 7 1947

Registration District No. **316**

Primary Registration District No. **6075**

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town River Mines, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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 Minnie Belle Shelton

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

4. Sex Female 5. Color or race Caucas 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife William Shelton 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 17 1872
(Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business Self

MOTHER FATHER } 12. Name William Wiatt
13. Birthplace Bellview Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Martha Imboden
15. Birthplace Bellview Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant William Shelton

(b) Address St. Louis, Mo.

17. (a) Burial (b) Date thereof Mar - 25 - 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Adetson, Mo #21

18. (a) Signature of funeral director Sparks Funeral Home

(b) Address 300 Taylor Flat River, Mo.

19. (a) 3-28-47 (b) Esther Rudloff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois
(c) City or town River Mines
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23
year 1947 hour 5:30 minute _____ A.M.

21. I hereby certify that I attended the deceased from Dec. 1st
1945, to March 22, 1947;
that I last saw her alive on March 22, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage Duration 24hr.

Due to Hypertension

Due to Arteriosclerosis

Other conditions: _____
(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 W.D. Morris, D.D. (M.D. or other) DD
Address Elwood Mo. Date signed 3-25-47

RECEIVED

District Health Officer No. 4
Registration Number 447-496
Date 4-2-47

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 Murphy L Sparks
Licensed Embalmer No. 4236
P. O. Address Flat River, 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.