U.S. No. 300
Rev. 10-48

FILED DEC 31 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41909

BIRTH NO. _____ REG. DIST. NO. 101 PRIMARY REG. DIST. NO. 4173 Registrar's No. 67

0340
1

1. PLACE OF DEATH
a. COUNTY: Douglas
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ava
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Douglas
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ava 0340
d. STREET ADDRESS (If rural, give location): 0

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last): Sarah Alice Shelton

4. DATE OF DEATH (Month) (Day) (Year): 12-4-52

5. SEX: Female 1
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 1-1-70
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Brookfield, Ind. 1
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: William Graham
13b. MOTHER'S MAIDEN NAME: Jane Inlow
14. NAME OF HUSBAND OR WIFE: John Shelton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): N
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: ✓ Mrs W.E. Rippee — ADDRESS: Mtn Grove Mo

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Adhesion — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Heart Failure
DUE TO (c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 4201
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 3, 1952, *to* Dec 4, 1952, *that I last saw the deceased alive on* Dec 4, 1952 *and that death occurred at* 8:40P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W.E. Shannon M.D.
23b. ADDRESS: Ava, Mo.
23c. DATE SIGNED: Dec 9/52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-7-52
24c. NAME OF CEMETERY OR CREMATORY: Whitescreek
24d. LOCATION (City, town, or county) (State): Ava, Missouri

DATE REC'D BY LOCAL REG.: 12-29-52
REGISTRAR'S SIGNATURE: Vestal Bushman 84-0
25. FUNERAL DIRECTOR'S SIGNATURE: Clinkingbeard Funeral Home, Ava, Mo.
ADDRESS:

(Licensed Embalmer's Statement on Reverse Side)

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

2
0

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 _____

_____, Student Embalmer No. _____,

working under my personal supervision.

Student _____
Student Embalmer

Signed Charles R. Fish

Licensed Embalmer No. 4662

P. O. Address Ava, 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.