

FILED AUG 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28528**

BIRTH NO. _____ REG. DIST. NO. **275** PRIMARY REG. DIST. NO. **3053** Registrar's No. **153**

1. PLACE OF DEATH a. COUNTY Phelps		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Misouri b. COUNTY Dent	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rolla	c. LENGTH OF STAY (in this place) 1 1/2 yrs	c. CITY OR TOWN Salem	d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION McFarland Nursing Home		e. STREET ADDRESS (If rural, give location) -----	

3. NAME OF DECEASED (Type or Print)	a. (First) JAMES	b. (Middle) MARION	c. (Last) SHELTON	4. DATE OF DEATH (Month) (Day) (Year) August 15 1954
-------------------------------------	-------------------------	---------------------------	--------------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 4, 1876	9. AGE (in years last birthday) 78	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) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Agriculture	11. BIRTHPLACE (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
--	---	---	--

13a. FATHER'S NAME Robert J. Shelton	13b. MOTHER'S MAIDEN NAME Sarah M. Skeeters	14. NAME OF HUSBAND OR WIFE Nancy Emma Shelton
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Clarence Shelton, Cora, Ill.
---	--	--

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia		3 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Cerebral Vascular Accident		4 days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Parkinsonism Generalized Arteriosclerosis	8 years 6 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	---	---

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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from **Aug 13, 1954**, to **Aug 13, 1954**, that I last saw the deceased alive on **Aug 13, 1954**, and that death occurred at **9:10a m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. V. Giam	23b. ADDRESS MD 9 Rolla Mo.	23c. DATE SIGNED Aug 17, 1954
---	---------------------------------------	---

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 8/15/54	24c. NAME OF CEMETERY OR CREMATORY Green Forest Cem.	24d. LOCATION (City, town, or county) (State) Dent County Missouri
---	-----------------------------	--	--

DATE REC'D BY LOCAL REG. Aug 17, 1954	REGISTRAR'S SIGNATURE Nadine L. Stoll	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Blackwell-Crawley Salem, Mo.
---	---	---

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

County File Number _____

Date Filed AUG 29 1954

AUG 25 1954

OCT 8 1954

SEP 20 1954

SEP 20 1954

OCT 1 1954

SEP 28 1954

OCT 4 1954

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 _____
Signature of Student Embalmer

Signed Max L. Warfield

Licensed Embalmer No. 417

P. O. Address Salem

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.