

pt. Health,  
, & Welfare  
S. Public  
th Service

FILED MAY 14 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13768  
STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. 5625 Registrar's No. 78

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sleeper-AUGLAIZE-TS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Sleeper</u>		0530 0 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>Sleeper</u> INSTITUTION			Length of stay in lb <u>30 Yrs.</u>		d. STREET ADDRESS <u>Sleeper</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>REUBEN</u> Middle <u>T.</u> Last <u>SHELTON</u>				4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 16, 1878</u>		9. AGE (In years of birthday) <u>78</u> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (City and state or country) <u>Pulaski County Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Mark Shelton</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy Brummley</u>			14. NAME OF HUSBAND OR WIFE <u>Rhoda Shelton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>			16. SOCIAL SECURITY NO. <u>500-12-2056</u>		17. INFORMANT Address <u>Mrs. Edna Allen, Lebanon, Mo.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____									
PART-II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4222</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)						
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____									
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21- I attended the deceased from <u>Jan. 1957</u> to <u>April 22, 1957</u> and last saw her alive on <u>April 22, 1957</u> Death occurred at <u>8:00 A.M.</u> m in the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>W. Carrington, M.D.</u>					22b. ADDRESS <u>Lebanon, Mo.</u>			22c. DATE SIGNED <u>5-6-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5-6-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lebanon City Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Lebanon, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Lebanon, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>5-6-1957</u>		26. REGISTRAR'S SIGNATURE <u>Hella S. Day</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Secondary and medical certificates must be listed. No symptoms will be listed. All diseases in Part I must be causally related.

Received 4-13-57  
Laclede County Health Unit  
File No. 78  
Date Filed 4-13-57

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 S. P. Palmer.....

Licensed Embalmer No. 2208.....

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