

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16184

State File No. ....

FILED MAY 20 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 171

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Ozark</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Columbia</u>	c. LENGTH OF STAY (in this place) <u>10 days</u>	c. CITY OR TOWN <u>Souder</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>2770</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u>	b. (Middle) <u>Laverne</u>	c. (Last) <u>Shelton</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 13 57</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>infant</u>	8. DATE OF BIRTH <u>3-3-1956</u>
9a. AGE (In years last birthday) <u>1 yr.</u>	9b. IF UNDER 1 YEAR Months _____ Days _____	9c. IF UNDER 24 HRS. Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>Ova, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Arthur Shelton</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Margaret L. Strong</u>	14. NAME OF HUSBAND OR WIFE _____
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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>no</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Arthur Shelton Souder Missouri</u>	ADDRESS _____
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>NOT KNOWN</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>3932</u>		

19a. DATE OF OPERATION <u>UNKNOWN</u>	19b. MAJOR FINDINGS OF OPERATION <u>MASTOIDECTOMY (BURGE HOSP. SPRINGFIELD, Mo)</u>	20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>	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 May 3, 19 57, to May 13, 19 57, that I last saw the deceased alive on May 13, 19 57, and that death occurred at 6:47 pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Clement E. Blasche M.D.</u>	23b. ADDRESS <u>601 Missouri Medical Center Columbia Mo</u>	23c. DATE SIGNED <u>5/18/57</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>May 15, 57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Whites Creek Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Ozark Co. Mo</u>
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DATE REC'D BY LOCAL REG. <u>May 13, 1957</u>	REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>	25. FEDERAL DIRECTOR'S SIGNATURE <u>Charles F. ...</u>	ADDRESS <u>Columbia, Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

31-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed <sup>mal</sup>

by me, or by....., Student Embalmer No.....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Charles L. Fanning.....

Licensed Embalmer No...4132

P. O. Address Alameda.....

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.