

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-028146  
STATE FILE NUMBER

FILED AUG 20 1958

Registration District No. 27 Primary Registration District No. 3005 Registrar's No. 105

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Bates</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Bates</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Butler</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Butler</b> <b>0071</b> <b>0</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>306 East Walnut</b>		Length of stay in lb <b>40 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>306 East Walnut St</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>BELLE</b> Last <b>SHELTON</b>			4. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>1958</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <b>2</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8 1869</b>	9. AGE (In years 160 (in days) <b>89</b> )	IF UNDER 1 YEAR Months Days <b>10</b> <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>MO. e</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>William Cofer</b>		13b. MOTHER'S MAIDEN NAME <b>Martha-----</b>		14. NAME OF HUSBAND OR WIFE <b>Andrew H Shelton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Dwight Shelton-Adrian Missouri</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>left side heart failure</b>					INTERVAL BETWEEN ONSET AND DEATH <b>7 days.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>infirmities of old age and malnutrition</b>					<b>2 years.</b>
DUE TO (c) <b>sebulicity</b>					<b>4342</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT 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 <b>JAN 1948</b> , to <b>July 19<sup>th</sup> '58</b> and last saw her <sup>her</sup> alive on <b>July 19-58</b> Death occurred at <b>11:30 Pm</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>L. S. Lathrop, M.D.</i>			22b. ADDRESS <b>Butler Missouri</b>		22c. DATE SIGNED <b>July 20-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
<b>Burial</b>		<b>July 22-58</b>	<b>Oakhill Cemetery</b>		<b>Butler Missouri</b>
24. FUNERAL DIRECTOR <b>Culver Underwood Butler Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>July 22-1958</b>	26. REGISTRAR'S SIGNATURE <i>Rendall Kroy</i>	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Robert D. Stumberch*

Licensed Embalmer No. 4657

P. O. Address Butler Missouri

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.