

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-031460

STATE FILE NUMBER

FILED AUG 22 1958

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. 155

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Scott</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Arkansas</b> b. COUNTY <b>Izzard</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Sikeston</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Ash Flat</b> <b>8038</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Delta Comm. Hosp.</b>		Length of stay in 1b <b>1 Day</b>	d. STREET ADDRESS (If outside, give location) <b>Route #1</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>JEFFERSON</b> Last <b>SHELLEY</b>	4. DATE OF DEATH Month <b>8</b> Day <b>6</b> Year <b>1958</b>
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5. SEX <b>Male</b> <input checked="" type="checkbox"/>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-6-1893</b>	9. AGE (In years last birthday) <b>65</b>	F UNDER 1 YEAR Months <b>2</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Arkansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>William Shelley</b>	13b. MOTHER'S MAIDEN NAME <b>Leann Clinton</b>	14. NAME OF HUSBAND OR WIFE <b>Eula Kent</b>
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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) <b>0</b>	16. SOCIAL SECURITY NO. <b>0</b>	17. INFORMANT <b>Mrs. Eula Shelley, Ash Flat, Ark.</b> Address
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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>coronary occlusion</b> DUE TO (b) <b>—</b> DUE TO (c) <b>—</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH <b>30 hours</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Generalized arteriosclerosis with cardiac decompensation</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>decompensation</b>
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20c. TIME OF INJURY Hour <b>—</b> Month <b>—</b> Day <b>—</b> Year <b>—</b> a.m. <b>—</b> p.m. <b>—</b>	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.) <b>—</b>	20f. CITY, TOWN, OR LOCATION <b>4201</b>	COUNTY <b>—</b>	STATE <b>—</b>
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21. I attended the deceased from <b>8-5-58</b> to <b>8-6-58</b> and last saw him alive on <b>8-6-58</b> Death occurred at <b>11:00 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>E. D. Urban, M.D.</b> (Degree or title)	22b. ADDRESS <b>Sikeston, Mo.</b>	22c. DATE SIGNED <b>8-7-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>Aug. 8-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wiles Cemetery</b>	23d. LOCATION (City, town, or country) (State) <b>Ash Flat, Arkansas</b>
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24. FUNERAL DIRECTOR <b>Delbert T. Fennel</b>	ADDRESS <b>Sikeston, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>8-11-58</b>	26. REGISTRAR'S SIGNATURE <b>Miss Eula Hunter</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

8581 24 007

DATE RECEIVED 8-18-58

SCOTT CO. HEALTH DEPT.

CO. FILE No. 858-201

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 Earl J. Smith  
Licensed Embalmer No. 2676  
P. O. Address Osage 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.