

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006210

STATE FILE NUMBER

FILED MAR 11 1959

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 37

300
-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>Camden</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Stoutland</u> 1156 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wallace Hospital</u>		Length of stay in lb <u>3 Weeks</u>	d. STREET ADDRESS (If outside, give location) <u>Stoutland</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>A.</u> Last <u>SHELDON</u>			4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1883</u>
9. AGE (In years at birth) <u>76</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>	11. BIRTHPLACE (City and state or country) <u>Anño, Wisconsin</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Fred W. Sheldon</u>	
13b. MOTHER'S MAIDEN NAME <u>Ella Hutchison</u>		14. NAME OF HUSBAND OR WIFE <u>Fannie Sheldon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Spanish American</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Fannie Sheldon</u>		Address <u>Stoutland, 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>Cancer of esophagus with Metastases.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>one year</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>15px</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input checked="" 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.) <u>15px</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION <u>6/9/53</u> to <u>3/1/59</u> and last saw her alive on <u>3/1/59</u>		COUNTY _____ STATE _____	
21. I attended the deceased from death occurred at <u>5:30 A.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>2092 Z. Fisher M.D.</u>		22b. ADDRESS <u>Lebanon, Mo</u>	
22c. DATE SIGNED <u>3/2/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>3/3/59</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington Ceme.</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>	
24. FUNERAL DIRECTOR <u>J. Palmer</u>		25. DATE RECD. BY LOCAL REG. <u>3-3-1959</u>	
ADDRESS <u>Lebanon, Mo</u>		26. REGISTRAR'S SIGNATURE <u>Hella L. May</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Date Filed MAR 9 1959

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 *Stanley R. Palmer*

Licensed Embalmer No. *4810*

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.