

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024408

FILED VS AUG 4 1959 53

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268

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

DED

1. PLACE OF DEATH a. COUNTY Cape Girardeau				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cape Girardeau			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cape Girardeau		Length of stay in 1b 35 years		c. CITY OR TOWN Cape Girardeau		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 1250 Normal Ave.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1250 Normal Ave.			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MITCHEL Middle H. Last SHELBY				4. DATE OF DEATH Month July Day 29 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4/14/1891	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months 3 Days 15	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor, ret.		10b. KIND OF BUSINESS OR INDUSTRY Own Practice		11. BIRTHPLACE (City and state or country) Charleston, Missouri		12. CITIZEN OF WHAT COUNTRY U. S.	
13a. FATHER'S NAME Elbert Shelby			13b. MOTHER'S MAIDEN NAME Josephine DeLine		14. NAME OF HUSBAND OR WIFE Lucy L. Shelby		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	17. INFORMANT Address Mrs. W. W. Crites Jackson, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Pulmonary Emphysema, severe						10 yrs	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Amyotrophic lateral sclerosis						10 yrs	
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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.		Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <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 May 26th, 1959 to July 29, 1959 and last saw her alive on July 29, 1959 Death occurred at 5:00 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Charles P. W. Smith M.D.				22b. ADDRESS Cape Girardeau, Missouri			22c. DATE SIGNED 7/30/59
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE July 31, 1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.		23d. LOCATION (City, town, or county) (State) Cape Girardeau, Missouri		
24. FUNERAL DIRECTOR ADDRESS Walther's Funeral Home Cape Gir. Mo.			25. DATE RECD. BY LOCAL REG. 7-30-59	26. REGISTRAR'S SIGNATURE Gene Kasten			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 1 1 1959

AUG 2 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 _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William Lee Townes

Licensed Embalmer No. 24410

P. O. Address Cape Girardeau

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.