

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-014542

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 57

DO NOT WRITE ON THIS STUB  
AMENDED

VS 300  
Rev. 4/59

6975

2970

3

4 0

5 1

6

7 0

8 0

9331X

10

11

12 1-0

13 3-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marshall</b>		Length of stay in 1b <b>2 months</b>		c. CITY OR TOWN <b>Marshall</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Fitzgibbon Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>RFD#3</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES ROBERT SHELLENBERGAR</b>			4. DATE OF DEATH Month Day Year <b>March 11, 1963</b>		
5. SEX <b>Male</b>		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>9-23-1884</b>		9. AGE (last birthday) <b>78</b>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (City and state or country) <b>Saline County, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Matthew Peter Shellenbergar</b>		13b. MOTHER'S MAIDEN NAME <b>Sedalia Price Bullard</b>	
13c. NAME OF HUSBAND OR WIFE <b>Ida Lena Shellenbergar</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Raymond Shellenbergar, Independence</b>		17. Address			
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>Cerebral Hemorrhage</b> 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) 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 <u>12-27-62</u> to <u>3-11-63</u> and last saw him alive on <u>3-11-63</u> Death occurred at <u>10:15pm.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>James A. Reed MD</i>		(Deceased or Title)		22b. ADDRESS <i>Marshall Mo</i>	
22c. DATE SIGNED <i>3-12-63</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-14-1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ridge Park Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>Marshall, Missouri</b>		24. FUNERAL DIRECTOR <b>Campbell-Lewis</b>		25. DATE RECD. BY LOCAL REG. <b>3-13-'63</b>	
24. ADDRESS <b>Marshall, Mo.</b>		26. REGISTRAR'S SIGNATURE <i>Carl J. Reed</i>			

USE BLACK INK OR TYPEWRITER RIBBON

**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,

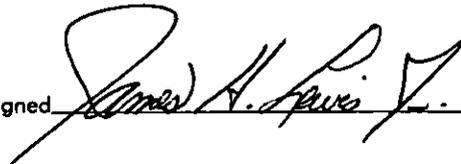
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed



Licensed Embalmer No. 4709

P. O. Address Marshall, 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.