S. No. 2
M—1/47
r. 5-17-39

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED MAY 26 1948
Registration District No. 3882

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16154
Primary Registration District No. 4230
Registrar's No. 6

1. PLACE OF DEATH:
(a) County Howard
(b) City or town Armstrong Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: at home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 6 Weeks
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Howard
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Armstrong R. R.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME SHARON KAY SHIFLETT
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife No
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 4th (Day) 1940 (Year)

8. AGE: Years	Months	Days	If less than one day
	1	22	hr. min.

9. Birthplace LEE Hospital Mo (City, town, or county) (State or foreign country)
10. Usual occupation none
11. Industry or business
MOTHER
12. Name Melvin Shiflett
13. Birthplace Mo (City, town or county) (State or foreign country) 0
14. Maiden name Evelyn Rose Brooks 0
15. Birthplace Mo (City, town, or county) (State or foreign country)
FATHER
16. (a) Informant Mrs Tom Shiflett
(b) Address Armstrong
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 29 48 (Month) (Day) (Year)
(c) Place: burial or cremation Walnut Ridge Cem
18. (a) Signature of funeral director H S Robinson
(b) Address Armstrong Mo
19. (a) 3-25-48 (Date received local registrar) (b) Mrs Joe Kaiser (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28th year 1948 hour 2 PM minute M.
21. I hereby certify that I attended the deceased from Birth, 19, to 2-27, 1948; that I last saw him alive on Jan. 18, 1948; and that death occurred on the date and hour stated above.

Cause	Duration
Immediate cause of death: Acute respiratory Arrest	2 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Hydrocephalus, spina bifida	Birth
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other) M.D.
Address Fayette, Mo. Date signed 3-3-48

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 5-25-48

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

Registered Apprentice No.

working under my personal supervision.

Signed H. S. Robinson

Licensed Embalmer No. 3007

P. O. Address Armstrong

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 this body is not embalmed, fact should be so stated above.