WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

48374

PLACE OF DEATH

County St Louis Mo

Township Meramec

or

Village Centaur

or

City Mo (NO. ..... St.: ..... Ward)

Registration District No. 785

Primary Registration District No. 6032

File No. .....

Registered No. 192

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Charles Shelton

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)

DATE OF BIRTH: June (Month) 9 (Day), 1905 (Year)

AGE: 13 yrs. 5 mos. 23 ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

BIRTHPLACE (City or town, State or foreign country): Franklin Co Mo

PARENTS

NAME OF FATHER: G W Sheldon

BIRTHPLACE OF FATHER (City or town, State or foreign country): Cole Co Mo

MAIDEN NAME OF MOTHER: M. Anna Linville

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Cole Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T D Terry

(ADDRESS) Centaur Sta

Filed 12/14, 1918. C A Dunnavant REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec (Month) 6th (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 1, 1918, to Dec 6, 1918, that I last saw him alive on Dec 6, 1918, and that death occurred, on the date stated above, at 5.25 a.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

94A

11B (Duration) ..... yrs. ..... mos. ..... ds.

10

Contributory (SECONDARY) Influenza

(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) Robert Terry Jr M. D.

Dec 7, 1918 (Address) Chesterfield Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL: Anti arch

DATE OF BURIAL: Dec 7, 1918

UNDERTAKER: J Leinecke

ADDRESS: Centaur Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., *1*.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,

that I last saw h.....alive on ....., 191.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)
.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191..... . (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very import