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

Do not use this space.

8111

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. 5608 Pershing St. ..... Ward)

File No. ..... Registered No. 2481

2. FULL NAME Claude L. Sellers

(a) Residence. No. 5608 Pershing St., 5 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Mildred Sellers

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 1 – 1884

7. AGE: Years 46 | Months 1 | Days 20 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: Self

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Prescott Kans

PARENTS

10. NAME OF FATHER: Dr. L. R. Sellers
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Anderson Ind
12. MAIDEN NAME OF MOTHER: Alice B. Goss
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Gosport Ind

14. INFORMANT: Mrs. Mildred Sellers
(Address) 5608 Pershing Ave

15. FILED ..... 19..... Max C. Tandy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb. 21 1931

17. No Physician in attendance
I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 10:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gunshot Wound of Head
Whether accidental or intentional could not be ascertained
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Kerner M.D.
2/23 1931 (Address) Dep. Coron

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Fort Scott Kans
DATE OF BURIAL: 2-25 1931

20. UNDERTAKER: Mayer Und Co
ADDRESS: 4356 Lindell

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.