

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

Do not use this space.

16120

**1. PLACE OF DEATH**

County..... Registration District No. 701  
Township..... Primary Registration District No. 1003  
City St. Louis (No. City Hospital)

File No.....  
Registered No. 4597  
St. .... Ward)

**2. FULL NAME**

Edw. Shackelford  
(a) Residence. No. 309 St. Georges, ..... 23 Ward. (If nonresident, give city or town and State)  
(Usual place of abode)

Length of residence in city or town where death occurred 7 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 Mattie Shackelford

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 15-1873

7. AGE	YEARS	MONTHS	DAYS	IF LESS THAN 1 day, ..... hrs. or ..... min.
	<u>57</u>	<u>4</u>	<u>1</u>	

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind.

10. NAME OF FATHER Wm. Shackelford

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ind.

12. MAIDEN NAME OF MOTHER Annie Lemous

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ill

14. Hospital Information INFORMANT Ernest Kopp (Address) City Hospital

15. FILED 6 19 31 Wm. C. Stark REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 16th 1931

17. I HEREBY CERTIFY, That I attended deceased from April 3rd, 1931, to April 16th, 1931, that I last saw him alive on April 16th, 1931, and that death occurred, on the date stated above, at 8:45 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

108  
Lobar Pneumonia  
(duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) 108  
(duration) .... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Chinical; X-ray  
(Signed) Ernest Kopp, M. D.

416 (1931) (Address) City Hosp

\*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 <u>Lilbourn Mo.</u>	DATE OF BURIAL <u>April 17 1931</u>
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20. UNDERTAKER <u>Ward-Hall</u>	ADDRESS <u>2331 P. Ring</u>
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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.

