

*Mr. Eldridge*

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

Do not use this space.

6747 Brookside  
Hi 4770 - SEP 30 1934

5740 Central  
In 7793-399  
1002

29619

PLACE OF DEATH  
County *Jackson* Registration District No. *5740 Central*  
Township *Kansas City West* Primary Registration District No. *1002*  
City *Mercy Hospital* No. *1002* St. *1002* Ward

2. FULL NAME *Tremont B. Shull*

(a) Residence, No. *1 Sale, Missouri* Ward. (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 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) *Single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 23-34*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*0 1 8 35*

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Child*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *State, Mo*

13. NAME *Joy Shull*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

15. MAIDEN NAME *Opol. Lyons*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

17. INFORMANT *Joy Shull* (ADDRESS) *State, Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *State, Mo* DATE *9-1-34*

19. UNDERTAKER *Mrs. O. L. Foster* (ADDRESS) *State, Mo*

20. FILED *8/31 1934* *J. M. Crowe* Registrar.

4 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *8-27-1934*

22. I HEREBY CERTIFY, That I attended deceased from *8-30-34* 19... to *8-31-34* 19...  
I last saw him alive on *8-27-34* 19... Death is said to have occurred on the date stated above, at *4:35* m.  
The principal cause of death and related causes of importance were as follows:  
*Pan-Sinusitis* Date of onset *8-26-34*  
*Orbit of cellulitis*  
*Suppurative*  
*Thrombosis of paranasal sinuses*  
Other contributory causes of importance:  
*no*

Name of operation *no* Date of *no*  
What test confirmed diagnosis? *Autopsy* Was there an autopsy? *yes*

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? Date of injury, 19...  
Where did injury occur? (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *—*  
Nature of injury *—*

24. Was disease or injury in any way related to occupation of deceased? *no*  
If so, specify  
(Signed) *Charles J. Eldridge*, M. D.  
(Address) *6247 Brookside*

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.

5740 Central

Jan 7293

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