

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

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.

JUN 15 1940 791
Registration District No.

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Central Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME William Clifford Sheldon

8. (b) If veteran, name war _____ 8. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Madelin Sheldon 6. (c) Age of husband or wife if alive Dead years

7. Birth date of deceased Feb. 9, 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 2 23 hr. min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Pressman

11. Industry or business Newspaper

12. Name (Not known) Sheldon

13. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace Not known Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Annie Maul, Jr.
(b) Address 4449 Greer Ave.

17. (a) Burial (b) Date thereof May 4, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Charles W. ...
(b) Address 4911 Washington Blvd.

19. (a) MAY 3 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 10
(If outside city or town limits, write "RURAL")
(d) Street No. 4449 Greer Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2
year 1940 hour 5 minute 0 M.

21. I hereby certify that I attended the deceased from 12/1/38
_____, 19____, to 5/2, 1940
that I last saw him alive on 5/2, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 2 yrs

Due to Erysipelas 12/1/38, 7/12/39, 7/15/39

Due to 93C

Other conditions Amputation left leg; 5/1/40
(Include pregnancy within _____ months of death)

Caused by cellulitis
Major findings: cellulitis, caused by Erysipelas
Of operations _____
Of autopsy None

PHYSICIAN

Underline the cause to 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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Edwin J. ... (M. D. or other) [Signature]
Address 3635 Ave. ... Date signed 5/4/40

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 Thomas R. Kenwick

Licensed Embalmer No. 3793

P. O. Address St. Louis Mo

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, above space should be left blank.