

No. 2  
11-10-39  
5-17-39  
I X21492

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

16921

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. **4402**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(c) Name of hospital or institution: Missouri Baptist Hospital  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St Louis  
(d) Street No. 5729 Vernon Ave  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15th  
year 1940 hour 11 minute 30pm M.

21. I hereby certify that I attended the deceased from May 13, 1940, to May 15, 1940,  
that I last saw him alive on May 15, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Obstructive Pulmonary 1 wk

Due to Calculation of mouth ( Ludwig Angina ) 1 wk  
Due to ruptured teeth

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_

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? \_\_\_\_\_  
(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: [Signature] (M. D. or other) MD  
Address: 409 Kuster Road Date signed: 5-17-40

3. (a) PRINT FULL NAME Ira E. Shelton 435  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. 491-18-8521

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

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased About 1879  
(Month) (Day) (Year)

8. AGE: Years About 61 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Classified. Ad.

11. Industry or business St. Louis Star Times

12. Name ZACH Shelton

13. Birthplace Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Carrie Link

15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Lester Shelton

(b) Address 4436 Margaretta Ave

17. (a) Burial (b) Date thereof 5/18/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery  
Stroot - Carroll

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address 4600 Natural Bridge Ave

19. (a) MAY 17 1940 (b) [Signature]  
(Date received local registrar)

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

MOTHER FATHER

**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

*Frank H. Howard*

Licensed Embalmer No. 2265

P. O. Address .....

**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.**