No. 2
4-13-40
5-17-39
I X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

43952

State File No. 43952

FILED JAN 8 1984

Registration District No. 1984 Primary Registration District No. 200 Registrar's No. 2357

1. PLACE OF DEATH:
(a) County: St. Louis County
(b) City or town: Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: Admitted 11/25/40 (Specify whether years, months or days)
In this community: unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State: Illinois (b) County:
(c) City or town: East St. Louis (If outside city or town limits, write "RURAL")
(d) Street No.: 1719 East Broadway (If rural, give location)
(e) If foreign born, how long in U. S. A.? - years.

3. (a) PRINT FULL NAME: Charles Shelton
3. (b) If veteran, name war: World War
3. (c) Social Security No.: Unknown
4. Sex: Male
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Widower
6. (b) Name of husband or wife: -
6. (c) Age of husband or wife if alive: - years
7. Birth date of deceased: Unkn. (Month) Unkn. (Day) 1886 (Year)
8. AGE: Years 54 Months - Days - If less than one day hr. min.
9. Birthplace: LaGrange, (City, town, or county) Tennessee (State or foreign country)
10. Usual occupation: Butler
11. Industry or business:
MOTHER FATHER
12. Name: Unavailable
13. Birthplace: Unavailable (City, town, or county) (State or foreign country)
14. Maiden name: Unavailable
15. Birthplace: Unavailable (City, town, or county) (State or foreign country)
16. (a) Informant: M. Schilling
(b) Address: Clinical Clerk, VAF, Jeff. Bks., Mo.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-16-40 (Month) (Day) (Year)
(c) Place: burial or cremation: National Cemetery
18. (a) Signature of funeral director: Chas. J. Bales
(b) Address: 4107 Finney Avenue
19. (a) DEC 15 1940 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 10th year 1940 hour 7:14 minute p.m.
21. I hereby certify that I attended the deceased from November 25, 1940 to December 10, 1940 that I last saw him alive on December 10, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypertensive and coronary arteriosclerotic heart disease, marked cardiac enlargement, myocardial	
Due to: damage and myocardial insufficiency.	Unknown
Due to: -	
Other conditions: None. (Include pregnancy within 3 months of death)	
Major findings: Of operations: -	
Of autopsy: No autopsy.	

PHYSICIAN — Underline the cause to which death should be charged statistically.

B21

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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: C. W. HUGHES, M.D., (M. D. or other)
Address: Chief Medical Officer. Date signed 12/11/40

(Licensed Embalmer's Statement on Reverse Side)

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 James A. Johnson, Registered Apprentice No. ..... working under my personal supervision.

Signed James A. Johnson

Licensed Embalmer No. 3522

P. O. Address 4107 Finney Avenue

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.