

FILED OCT 18 1941

Registration District No. 2 Primary Registration District No. 1057

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town ST. LOUIS  
(c) Name of hospital or institution: Homer Phillips Hospital  
(d) Length of stay: In hospital or institution 1 mo. 9 days  
In this community 25 years

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County St. Louis  
(c) City or town St. Louis  
(d) Street No. 1726 Webster Ave  
(e) If foreign born, how long in U. S. A. Native (1P) years

3. (a) PRINT FULL NAME Sula Rodgers Shelton  
(b) If veteran, name war None  
(c) Social Security No. None  
(d) Sex Female (e) Color or race Col.  
(f) (a) Single, widowed, married, divorced Divorced  
(g) (b) Name of husband Jesse Rodgers  
(h) (c) Age of husband or wife if alive Unknown  
(i) Birth date of deceased 23 1890

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month September day 20  
year 1941 hour 6:15 minute P.M.  
21. I hereby certify that I attended the deceased from August 8 1941 to Sept 20 1941;  
that I last saw her alive on Sept 20 1941;  
and that death occurred on the date and hour stated above.

8. AGE: Years 50 Months 11 Days 21 If less than one day hr. min.

Immediate cause of death Carcinoma of Cervix Duration Abt 7 years

9. Birthplace Starkville Miss.  
10. Usual occupation Housewife  
11. Industry or business None  
12. Name Albert Weed  
13. Birthplace Starkville Miss  
14. Maiden name Unknown  
15. Birthplace Starkville Miss

Other conditions None  
Major findings: Of operations None  
Of autopsy None  
PHYSICIAN None  
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Orvell Shelton  
(b) Address 1726 Webster Ave  
17. (a) Burial (b) Date thereof Sept 25-1941  
(c) Place: burial or cremation Washington Park Cem.  
18. (a) Signature of funeral director Manuel Undertakers  
(b) Address 4259 Finney Ave.  
19. (a) 9-23-41 (b) [Signature]

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? None  
23. Signature [Signature] (M.D. or other) \_\_\_\_\_  
Address 2601 N Whittier Date signed 9-22-41

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

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

**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.....

*William C. McDowell*....., Registered Apprentice No.....  
working under my personal supervision.

Signed *William C. McDowell*

Licensed Embalmer No. *2114*

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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 30328

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. \_\_\_\_\_

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:  
Romer Phillips Hosp  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lula Rodgers Shelton

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased Oct 23 1894  
(Month) (Day) (Year)

8. AGE: Years 50 Months 11 Days 17  
(If less than one day \_\_\_\_\_ min.)

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

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) NOV 21 1941 (b) J. F. Braseck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
p. \_\_\_\_\_ to \_\_\_\_\_ p. \_\_\_\_\_, 19\_\_\_\_;

that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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? \_\_\_\_\_  
(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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

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