S. No. 2
DM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 22560

FILED JUL 20 1945

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 6189

**1. PLACE OF DEATH:**

(a) County: St. Louis

(b) City or town: (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1953a O'Fallon St. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: (Specify whether years, months or days)

In this community: 30 years

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Missouri (b) County: 66 21

(c) City or town: St. Louis 17 (If outside city or town limits, write "RURAL")

(d) Street No.: 1953a O'Fallon St. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: Mrs. Ada Shelton

3. (b) If veteran, name war: none

3. (c) Social Security No.: none

4. Sex: female

5. Color or race: white

6. (a) Single, widowed, married, divorced: married

6. (b) Name of husband or wife: Thomas Shelton

6. (c) Age of husband or wife if alive: 60 years

7. Birth date of deceased: June (Month) 11th. (Day) 1895 (Year)

8. AGE: Years 50 | Months 1 | Days 0 | If less than one day: hr. min.

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

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Rolla Kirkpatrick

FATHER 13. Birthplace: unknown (City, town, or county) unknown (State or foreign country)

MOTHER 14. Maiden name: unknown

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

16. (a) Informant: Mr. Thomas Shelton

(b) Address: 1953a O'Fallon St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7-14-45 (Month) (Day) (Year)

(c) Place: burial or cremation: Freedens Bem

18. (a) Signature of funeral director: Hy. Leidner U. Co.

(b) Address: 2223 St. Louis Ave.

19. (a) JUL 14 1945 (Date received local registrar) J. J. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 11th. year 1945 hour 8:25 a.m. minute M.

21. I hereby certify that I attended the deceased from April 15th, 1945, to July 7, 1945, that I last saw her alive on July 7, 1945 and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of esophagus | ? |
| 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: (M. D. or other) MD

Address: 2807 N. Grand Ave. Date signed: 7-12-45

(Licensed Embalmer's Statement on Reverse Side)

Dr. Arthur Jost
2807 N. Grand

## 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 John P. Buchholz

Licensed Embalmer No. 1674

P. O. Address 2223 St. Louis Ave

**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, fact should be so stated above.**