

S. No. 2
M-2-43
7. 5-17-39
X33667

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

15195

State File No. _____

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 4022

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: Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 hour
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 50
(c) City or town 2 Festus
(If outside city or town limits, write "RURAL") NR. 1
(d) Street No. 115 Behring
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME Shelton, Baby
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Apr day 30
year 1946 hour 2 minute 45 P M.

4. Sex male 5. Color or race W 6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 4-30-46
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Apr 30 1946 to Apr 30 1946
that I last saw h. i. M. alive on Apr 30 1946
and that death occurred on the date and hour stated above.

8. AGE: Years _____ Months _____ Days _____ If less than one day
hr. 30 min. _____

Immediate cause of death Multiple malformations spinal bifida Duration 1/2 hr
Due to Club feet
Malformed heart

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

Other conditions (Include pregnancy within 3 months of death) 157

10. Usual occupation newborn
11. Industry or business _____
12. Name Robert W. Shelton
13. Birthplace Carralton Mo
(City, town, or county) (State or foreign country)

Major findings: Of operations None Of autopsy No
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

14. Maiden name LaVonne Wright
15. Birthplace Vandalia Mo
(City, town, or county) (State or foreign country)
16. (a) Informant J. Wendland RN
(b) Address Lutheran Hospital
17. Herculaneum Mo Date thereof 5-1-46
(Burial, cremation, etc.) (Month) (Day) (Year)

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? _____

18. (a) Signature of funeral director Frank Ward Co.
(b) Address Festus Mo
19. (a) MAY 3 1946 J. F. Breda
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) _____ Means of injury _____
23. Signature Wendland (M. D. or other) MD
Address Herculaneum, Mo. Date signed 5/30/46

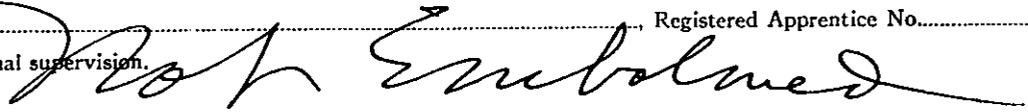
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
14095

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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.....

Licensed Embalmer No.....

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, fact should be so stated above.