No. 300
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FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25286

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6323

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
c. LENGTH OF STAY (In this place): 7 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis Children's Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Illinois
b. COUNTY: 994
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Marion
d. STREET ADDRESS (If rural, give location): N.R.

3. NAME OF DECEASED (Type or Print)
a. (First): Yolanda
b. (Middle): Sue
c. (Last): Shotton

4. DATE OF DEATH (Month) 7 (Day) 20 (Year) 49

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): (
8. DATE OF BIRTH: 7-6-49
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days 14 / IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Herrin, Illinois
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: William Howard Shotton
13b. MOTHER'S MAIDEN NAME: Virginia Crain
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Tracheo-esophageal fistula	>14 days
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Pneumonia, rt. chest	12 days
DUE TO (c)	Esophageal atresia	>14 days
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION: 7-18-49
19b. MAJOR FINDINGS OF OPERATION: Tracheo-esophageal fistula and Esophageal atresia
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 1.57 g

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 1.57 g

22. *I hereby certify that I attended the deceased from* 7-13, 1949, *to* 7-20, 1949, *that I last saw the deceased alive on* 7-20, 1949, *and that death occurred at* 10:15 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): Mel.
23b. ADDRESS: Marion Ill
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify):
24b. DATE: 7-21-49
24c. NAME OF CEMETERY OR CREMATORY:
24d. LOCATION (City, town, or county) (State): Marion Ill

DATE REC'D BY LOCAL REG.: JUL 21 1949
REGISTRAR'S SIGNATURE: J. B. Lazater
25. FUNERAL DIRECTOR'S SIGNATURE: Wm H. Shotton (Father) ADDRESS: Marion Ill

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

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.