

FILED APR 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11071

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2941**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION #1 Hospital			Length of stay in 1b 22/18		d. STREET ADDRESS (If outside, give location) 3512^a LAWTON		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Walter Shelton				4. DATE OF DEATH Month 3 - Day 24 - Year 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 25, 1894		9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. W. W. # 1		17. INFORMANT Virgie M. Shelton		Address 3512^a LAWTON Av.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal Hemorrhage following gunshot wound of the Abdomen; suffered when shot with gun in hands of one Frank Mosley (Col.) in room of home at 3512-a Lawton about 10:00 P.M., March 24, 1957;							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b)
DUE TO (c)							DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 1
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) See Above E 981X				
20c. TIME OF INJURY 10:30 Hour X Month X Day X Year p. m. 3-24-57							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) In Home		20f. CITY, TOWN, OR LOCATION St. Louis, Mo.		COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 10:30 P. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Joseph M. Quinn (Owner)				22b. ADDRESS 1300 Clark		22c. DATE SIGNED 3/24/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE MARCH-28, 1957	23c. NAME OF CEMETERY OR CREMATORY Fordyce ARK		23d. LOCATION (City, town, or county) (State) Fordyce ARK		
24. FUNERAL DIRECTOR Peoples Und. Co. 3100 Franklin Ave.				25. DATE RECD. BY LOCAL REG. MAR 27 '57		26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.	

(Licensed Embalmer's Statement on Reverse Side)

mjb

Health,
Welfare
Public
Service300
1-56

Doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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,
Signature of Student Embalmer

Signed *W. Claude Gordon*

Licensed Embalmer No. *346*

P. O. Address *4575 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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