

1. PLACE OF DEATH a. COUNTY St Louis Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		c. CITY OR TOWN ST, Loius	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Peoples Hospital		d. STREET ADDRESS (If outside, give location) 4660 Kennerly Ave	

3. NAME OF DECEASED (Type or print) First Inez Middle Shelton Last			4. DATE OF DEATH Month October Day 9 Year 1960		
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5. SEX Female	6. COLOR OR RACE Col	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 24 May 95	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months 3 Days 9	IF UNDER 24 HR Hours 9 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and state or country) Columbia Missouri	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME Henry Wilson	13b. MOTHER'S MAIDEN NAME ???	14. NAME OF HUSBAND OR WIFE Marton L. Shelton
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. No	17. INFORMANT Mr Marton L. Shelton	Address 4660 Kennerly Ave
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Pulmonary edema		1 1/2 hrs
DUE TO (b) Uremia		1 week
DUE TO (c) Acute glomerulonephritis		1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 590x		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from Aug-60 to Oct-60 and last saw her ^{him} alive on 10/9/60 Death occurred at 12:35 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE R. Williams, M.D. (Degree or title)	22b. ADDRESS 4701 A St. Louis	22c. DATE SIGNED 10/10/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/13/60	23c. NAME OF CEMETERY OR CREMATORY Jefferson Barracks	23d. LOCATION (City, town, or county) Jefferson Barracks Mo
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24. FUNERAL DIRECTOR Herman J. Smith	ADDRESS 4247 w Labadie Ave	25. DATE RECD. BY LOCAL REG. OCT 11 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Thomas M. Roberson

Licensed Embalmer No. 4479

P. O. Address East St 7

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.