

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 30 1961

20761-004129
STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 500 590 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rock Hill</u>		Length of stay in 1b	c. CITY OR TOWN <u>Rock Hill</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>509 Plateau Ave.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>509 Plateau Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MINNIE MAE SHELTON</u>			4. DATE OF DEATH Month Day Year <u>Jan. 19, 1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/11/1886</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>DENNISON Houston, Texas</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Sam Graham</u>		13b. MOTHER'S MAIDEN NAME <u>Ellen Savage</u>		14. NAME OF HUSBAND OR WIFE <u>William A. Shelton</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			17. INFORMANT Address <u>Wm. A. Shelton, 509 Plateau, W.G., Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-vascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) _____			
			DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				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.)		
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year					
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		
21. I attended the deceased from <u>Surg</u> <u>1957</u> to <u>Jan 19, 1961</u> and last saw her <u>live</u> on <u>Jan 6, 1961</u> Death occurred at <u>9:45 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>James B. Jones M.D.</u>			22b. ADDRESS <u>9813 Manchester Road St Louis 19, Mo.</u>		22c. DATE SIGNED <u>Jan 21, 1961</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/23/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kirkwood, Mo.</u>		
24. FUNERAL DIRECTOR <u>Parker-Aldrick, Webster Groves, Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>1-21-61</u>	REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>		

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

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 *Leslie Welch*

Licensed Embalmer No. 4395

P. O. Address Wester Grove

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.