

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

14982

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis*

Registration District No. *791*
Primary Registration District No. *1008*
(No. *Parkhurst Hotel*)

File No.....
Registered No. *3894*
St. Ward)

2. FULL NAME

Charlotte Kelly Selby

(a) Residence. No. *Parkhurst Hotel 19* Ward.
(Usual place of abode) *228 N. Taylor*

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *JAN 6 - 1841*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<i>87</i>	<i>3</i>	<i>2</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *at home*
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) *Wheeling*
(STATE OR COUNTRY) *W. Virginia*

10. NAME OF FATHER *Wm J. Selby*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) *Maryland*

12. MAIDEN NAME OF MOTHER *Jane Croas*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) *Virginia*

14. INFORMANT *Wm S. Mitchell*
(Address) *Parkhurst Hotel*

15. FILED *PP - 1 1928* *Mar C Starker* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 8 1928*

17. I HEREBY CERTIFY That I attended deceased from *Jan 17* 19*28* to *April 8* 19*28* that I last saw him alive on *April 7* 19*28*, and that death occurred, on the date stated above, at *5:42 p* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Emphysema of Lungs
Brain

CONTRIBUTORY (SECONDARY) *47*
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHICH TEST CONFIRMED DIAGNOSIS? _____

(Signed) *L. H. Simpson* M.D.
4/9 1928 (Address) *626 Independence Bldg*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Bellefontaine* DATE OF BURIAL *4-10 1928*

20. UNDERTAKER *Chas. Lupton Sons* ADDRESS *1219 Olive*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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