

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

Do not use this space.

12222

1. PLACE OF DEATH

County St. Louis Registration District No. 1160 File No. 30
 Township Central Primary Registration District No. 4470 Registered No. 1
 City University City (No. 7136, Foray the Blvd., St. _____ Ward)

2. FULL NAME Ebe Shellen

(a) Residence No. 7136 Foray the Blvd. St. _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 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.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widow

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1864-3-20

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
64 11 27

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) housewife
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT W.P. Melton
 (Address) 7136 Foray the Blvd.

15. FILED 3/18, 1929 Marie Brown
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/17 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, 19____, P. _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis 93C
 97

CONTRIBUTORY (SECONDARY) arterio-sclerosis
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? History (medical)
 (Signed) John O. Clumel M. D.

3/15 1929 (Address) Forum of Sports Society
 *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 Canton, Ohio DATE OF BURIAL 3/18 1929

20. UNDERTAKER Robert J. ... ADDRESS 429 W. ...
Chalidey

96
 1929
 2
 23
 7
 23
 2
 31
 31

WRITE PLAINLY WITH CAPITALS. 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.

