

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

Do not use this space.

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 10
 City Kansas City, (St. Marys' Hospital) St. _____ Ward _____

21357

File No. _____
 Registered No. 2488

2. FULL NAME Thomas Patrick Shelton

(a) Residence. No. 3031 Baltimore St. _____ Ward _____
 (Usual place of abode)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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) June 7 1888

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
42 11 26

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk
 (b) General nature of industry, business, or establishment in which employed (or employer) Kavanaugh Transfer Company
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Kansas

10. NAME OF FATHER Patrick Shelton

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

12. MAIDEN NAME OF MOTHER Rose McMahon

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

14. INFORMANT Mrs Edward Harvey
 (Address) 16 East 32nd St

15. FILED 6/4 1931 M. M. Crowe
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 3 1931

17. I HEREBY CERTIFY, That I attended deceased from May 31, 1931, to June 3, 1931, that I last saw him alive on June 3, 1931, and that death occurred, on the date stated above, at 12:20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Anaemia
131
132 B
 (duration) _____ yrs. mos. 6 ds.
 CONTRIBUTORY (SECONDARY) Chronic interstitial nephritis
 (duration) 1 yrs. mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? yes
 WHAT TEST CONFIRMED DIAGNOSIS Pathology

(Signed) [Signature] M. D.
June 4 1931 (Address) 1014 Angel Bedg Cells

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Mount Moriah Cemetery 6/5/31

20. UNDERTAKER ADDRESS

Quirk & Tobin--20 W Linwood

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

N. 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.

