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.

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

Do not use this space.

1. PLACE OF DEATH
96 County St. Louis — Registration District No. 785 — File No. 41415
Township Meramec — Primary Registration District No. 6032 — Registered No. 5
City Eureka, (No. ..... St. ..... Ward)

2. FULL NAME Ilene Shelton
(a) Residence. No. Eureka, Mo. St., ... Ward. ..... (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 0 yrs. 3 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

AN 27 1933

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: Single
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug. 31-1932
7. AGE: YEARS 0 — MONTHS 3 — DAYS 8 — If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None 10
(b) General nature of industry, business, or establishment in which employed (or employer): None 10
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St. Louis Co. Hospital Clayton Mo. 1

PARENTS
10. NAME OF FATHER: Elbert Shelton
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Miller Co Mo.
12. MAIDEN NAME OF MOTHER: Monte Scott
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Miller Co. Mo.

14. INFORMANT: Elbert Shelton
(Address) Eureka, Mo.
15. FILED 12/9 1932 C E Barnett MD REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec 9 1932
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw ..... alive on ....., 19....., and that death occurred on the date stated above, at 4 a m.
Hereby
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Third Child of triplets 3 Mo Old & extremely emaciated. Had no medical care was sick for 2 days with bad Cold (duration) ..... yrs. ..... mos. ..... ds.
From Coroners Dun Child had Fibrinous
CONTRIBUTORY (SECONDARY) Pneumonia. (duration) ..... yrs. ..... mos. 2 ds.
Died at 4:00 a.m. Dec 9/1932
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Place of death
DID AN OPERATION PRECEDE DEATH? NO DATE OF
WAS THERE AN AUTOPSY? NO
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Jacob B. Turner, M. D.
Dec 9/ 1932 (Address) 3718 Jennings Rd

*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: Burns Cem. — DATE OF BURIAL: Dec. 10 1932
20. UNDERTAKER: Schrader Und. Co. — ADDRESS: Ballwin Mo.