

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.

REGD AUG 11 1939 791  
Registration District No. 1003

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 5755 McPherson  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ni1  
(c) City or town St. Louis 5  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5755 McPherson Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 5  
year 1939 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from about  
January, 1938, to July 5, 1939  
that I last saw h. alive on July 5, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration \_\_\_\_\_  
arterial sclerosis

Due to Senility  
Chronic Cholecystitis  
Due to Probably stones

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN 93C  
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature H. E. D. [unclear] (M. D. or other)  
Address 5914 Delmar Date signed 7/5/39

3. (a) PRINT FULL NAME SALLIE ANN SHELTON 435  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Charles David Shelton 6. (c) Age of husband or wife if alive dec'd years \_\_\_\_\_

7. Birth date of deceased Oct. 11 1855  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
83 8 24 hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Troy Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Benedict Crump

13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Cochran

15. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Hewitt Creech

(b) Address 5755 McPherson Ave

17. (a) Burial (b) Date thereof July 8, 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Troy, Mo.

18. (a) Signature of funeral director WEBSTER GROVES FUNERAL HOME, Inc

(b) Address WEBSTER GROVES, MO.

19. (a) JUL 7 1939 (b) J. F. [unclear]  
(Date received local registrar) (Registrar's signature)

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*J. G. Sullivan*

Licensed Embalmer No..... 1122

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.