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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42060

State File No.

Registration District No. 284

Primary Registration District No. 200

Registrar's No. 2725

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town W. Walnut Manor

(c) Name of hospital or institution: 6615 W. Florissant Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether)

In this community Birth
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town W Walnut Manor
(If outside city or town limits, write "RURAL.")

(d) Street No. 6615 W. Florissant Ave
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Tillie Shelby

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 21,
year 1942 hour 2:20 Am minute 0 M.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Charles W. Shelby

6. (c) Age of husband or wife if alive ----- years

7. Birth date of deceased: January 1, 1859
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 7/10, 1939 to 12/21, 1942
that I last saw her alive on 12/20/42, 1942; and that death occurred on the date and hour stated above.

8. AGE: Years 83 Months 11 Days 20 If less than one day hr. min.

Immediate cause of death: Cerebral hemorrhage 3d
Uremia 3 days
Due to Chronic myocarditis
Arteriosclerosis.

9. Birthplace: St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation At home

Other conditions (Include pregnancy, within 3 months of death)

Major findings: None

Of operations None

Of autopsy None

11. Industry or business

12. Name George Hoffner

13. Birthplace New Orleans La.
(City, town, or county) (State or foreign country)

14. Maiden name Mary Kelly

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

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

(a) Accident, suicide, or homicide (specify) No

(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?

(Specify type of place) (e) Means of injury

16. (a) Informant Mrs E. L. Owens

(b) Address 6615 W. Florissant Ave

17. (a) Burial (b) Date thereof 12/24/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Math Hermann & Son

(b) Address 2161 East Fair Ave

19. (a) DEC 23 1942 (b) C. L. McLaughlin
(Date received local registrar) (Registrar's signature)

23. Signature C. L. McLaughlin (M. D. or other)

Address 5346 Oriole Date signed 12/22/42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

96
0
6

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 William G. Buehler

Licensed Embalmer No. 2119

P. O. Address St. Louis, Mo

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42060

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 2725

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town W. V. Adams Manor
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

3. (a) PRINT FULL NAME Jesse Shelby
3. (b) If veteran, name war _____ 3. (c) Social Security No. 1

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 83 Months 11 Days 20 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day _____ Year 1942 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
Chronic nephritis +
chronic myocarditis
arteriosclerosis
Due to _____
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____
131 h

PHYSICIAN
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work _____ (Specify type of place) (d) Means of injury _____
23. Signature Charles W. James MD (M.D. or other)
Address 5346 Oriole Date signed _____

SUPPLEMENTARY

