

7. S. No. 2
DOM-5-43
Rev. 5-17-39
I X3667

FILED FEB 1 1946

Registration District No. _____ Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
ALEXIAN BROS HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 WEEKS IN HOSPITAL
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howe's 96

(c) City or town St. Louis Gardenville
(If outside city or town limits, write "RURAL")

(d) Street No. 5132 Hilda St
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME WALTER L SHELTON

3. (b) If veteran, name war _____ 3. (c) Social Security No. 488-18-0611

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ella Shelton 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 3rd 1880
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>11</u>	<u>20</u>	_____ hr. _____ min.

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

10. Usual occupation Machinist

11. Industry or business _____

12. Name Albert Shelton

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

14. Maiden name Sarah Key

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

16. (a) Informant Ben T Shelton

(b) Address 5132 Hilda St

17. (a) ~~Burial~~ Warrenton Cem, Warrenton Mo Date thereof Jan 25 / 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Thaddeus's son

(b) Address 2906 Gravois Ave

19. (a) JAN 24 1946 (Date received local registrar) J. T. Bradish (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 23 year 1946 hour 3:00 A.M. 10 M.

21. I hereby certify that I attended the deceased from Jan 10, 1946, to 1-22, 1946 that I last saw him alive on 1-22, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Multiple pulmonary abscesses - bilateral

Due to non-tubercular cause unknown

Due to Pneumonia - Bron.

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

Major findings: lung

Of operations _____

Of autopsy yes - (above findings)

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)

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

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature Joseph L. Jones (M. D. or other) D

Address 4065-50 Grand Date signed 1/23/46

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

3115

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17
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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.....

Reg. J. Budde

Licensed Embalmer No. *3989*

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.