

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42809**
Registrar's No. **11190**

FILED DEC 17 1954

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH. a. COUNTY St. Louis Mo. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____ | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo. | | c. CITY OR TOWN St. Louis | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's Hosp. | | e. STREET ADDRESS (If rural, give location) 2019 7213 A. Minnesota | |

| | | | |
|--|--------------------------|--------------------------|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) TERRY | b. (Middle) DIANE | c. (Last) SHELTON | 4. DATE OF DEATH (Month) (Day) (Year) DEC. 7, 1954 |
|--|--------------------------|--------------------------|--|

| | | | | | | | |
|----------------------|-------------------------------|---|--|--|---------------------------|---------------------------|-------------------------|
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0 | 8. DATE OF BIRTH OCTOBER 21, 1947 | 9. AGE (In years last birthday) 7 YEARS | IF UNDER 1 YEAR Months | IF UNDER 12 HRS. Hours | IF UNDER 1 MIN. Min. |
|----------------------|-------------------------------|---|--|--|---------------------------|---------------------------|-------------------------|

| | | | |
|---|-----------------------------------|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) Mt. Vernon - Illinois | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|---|-----------------------------------|---|--|

| | | |
|--|--|-----------------------------------|
| 13a. FATHER'S NAME William E. Shelton | 13b. MOTHER'S MAIDEN NAME Boyer | 14. NAME OF HUSBAND OR WIFE _____ |
|--|--|-----------------------------------|

| | | |
|--|-------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. _____ | 17. INFORMANT'S SIGNATURE OR NAME J. Donahoe ADDRESS 500 S. Kingshighway |
|--|-------------------------------|--|

| | | | |
|--|--|--|----------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-resp. failure | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Brain (3rd vent.) tumor DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

| | | |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|----------------------------------|--|

| | | |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|--|--|---|

| | | |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from **Oct. 14, 1954**, to **Dec. 7, 1954**, that I last saw the deceased alive on **Dec. 7, 1954**, and that death occurred at **11:55 a.m.**, from the causes and on the date stated above.

| | | |
|---|---|---------------------------------|
| 23a. SIGNATURE Dr. J. Thurston (Degree or title) | 23b. ADDRESS 500 S. Kingshighway | 23c. DATE SIGNED 12-8-54 |
|---|---|---------------------------------|

| | | | |
|--|--------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 12-8-54 | 24c. NAME OF CEMETERY OR CREMATORY Local | 24d. LOCATION (City, town, or county) (State) Mount Vernon, Ill. |
|--|--------------------------|---|---|

| | | |
|--|--|---|
| DATE REC'D BY LOCAL REG. DEC 8 1954 | REGISTRAR'S SIGNATURE J. Earl Smith, M.D. | 25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington Blvd |
|--|--|---|

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

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John B. Binkley*.....
Licensed Embalmer No. *365*
P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.