

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

9273-61-034939
STATE FILE NUMBER

318 1003
Primary Registration District No. Registrar's No.

FILED OCT 13 1961
District No.

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b. 4 Days	c. CITY OR TOWN Sesser		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Gen. Delivery		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cole Middle Last Shelton			4. DATE OF DEATH Month 10 Day 5 Year 61			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-25-1894	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY School Teacher	11. BIRTHPLACE (City and state or country) Jefferson Co, Ill.	12. CITIZEN OF WHAT COUNTRY U. S. A.		
13a. FATHER'S NAME JAMES FRANK Shelton		13b. MOTHER'S MAIDEN NAME Ohlie Cole		14. NAME OF HUSBAND OR WIFE HAZEL		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			17. INFORMANT Hazel Shelton		Address Sesser, Ill	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalopathy due to Art. Sclerotic Central Arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 4 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Hypertensive Heart Disease		DUE TO (c) 332x			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arterial Sclerosis				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION	COUNTY	STATE	
21. I attended the deceased from 10-1-61 to 10-5-61 and last saw her/him alive on 10-5-61 Death occurred at 2:00 PM m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE Carl J. Reis M.D. (Degree or title)			22b. ADDRESS 1824 Humphreysway		22c. DATE SIGNED 10-6-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-8-61	23c. NAME OF CEMETERY OR CREMATORY Maple Hill		23d. LOCATION (City, town, or county) Sesser, Ill, Illinois	(State)	
24. FUNERAL DIRECTOR BRAYFIELD		ADDRESS Sesser, Ill	25. DATE RECD. BY LOCAL REG. OCT 7 1961	26. REGISTRAR'S SIGNATURE Roald Smith, M.D.		

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 Frank Proff

Licensed Embalmer No. 4356

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.