

2792

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

Registration District No. 1003

Registrar's No. 11466

-62-044863

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED DEC 7 1962

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Length of stay in 1b _____
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CITY HOSPITAL #1 Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY _____
c. CITY OR TOWN ST. LOUIS Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 1439 FRANCIS Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
ELIZABETH SHELTON 11 - 26 - 62

5. SEX Female 6. COLOR OR RACE Colored 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 10/8/1913 9. AGE (last birthday) 49 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and state or country) DUMAS, ARK 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Lindsey Wilkerson 13b. MOTHER'S MAIDEN NAME Rosie Johnson 14. NAME OF HUSBAND OR WIFE Jessie Shelton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. _____ 17. INFORMANT MAXINE SMITH Address 3301 VISTA

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Dilatation of Heart INTERVAL BETWEEN ONSET AND DEATH _____
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 4344
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____
PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 _____ to _____ and last saw her/him alive on _____
Death occurred at 6:03 9 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Paul J. Simon Deputy Coroner 22b. ADDRESS 1300 Clark 22c. DATE SIGNED 11/29/62

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 23b. DATE 12/3/62 23c. NAME OF CEMETERY OR CREMATORY Green Wood 23d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MO

24. FUNERAL DIRECTOR W. ROBINSON & SONS ADDRESS 2911 FRANKLIN 25. DATE RECD. BY LOCAL REG. NOV 29 1962 26. REGISTRAR'S SIGNATURE Lois Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

FILED DEPT. OF HEALTH

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 [Signature]

Licensed Embalmer No. 4628

P. O. Address 1238 W. Kingshighway
St Louis 13, 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.