

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-018225

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4273**

**FILED APR 23 1963**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED  
**5-9-63**  
**5-9-63**

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
**1-6-1887**  
**76**

DOCUMENT  
**1888**  
**1888**

BY AFFIDAVIT OF **informant**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>6635 Arsenal St.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>6635 Arsenal St.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>A.</b> Last <b>SHELDON</b>			4. DATE OF DEATH Month <b>Apr.</b> Day <b>16</b> Year <b>1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-6-1887</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrical Estimator-Schneider Electric Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>St. Louis, Mo.</b>	9. AGE (last birthday) <b>76 75</b> IF UNDER 1 YEAR: Months Days IF UNDER 24 HR: Hours Min.
11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <b>James Sheldon</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Howard</b>	14. NAME OF HUSBAND OR WIFE <b>Agnes B. Sheldon</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>No None</b>		16. SOCIAL SECURITY NO. <b>4</b>	17. INFORMANT Address <b>Agnes Sheldon 6635 Arsenal St.</b>
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Arteriosclerotic Cerebral Vascular Disease</b> DUE TO (c) <b>331X</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>
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. <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 Month, Day, Year a.m. p.m.		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 <b>11-14-62</b> to <b>4-16-63</b> and last saw him alive on <b>13 April 63</b> Death occurred at <b>7:45 A.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>John J. McClain M.D.</b>		22b. ADDRESS <b>4401 Hampton</b>	22c. DATE SIGNED <b>17 April 63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Apr. 19, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>APR 17 1963</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>

USE BLACK INK OR TYPEWRITER RIBBON

**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 Ernest W. Spillers

Licensed Embalmer No. 4080

P. O. Address \_\_\_\_\_

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.