DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 29 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

29064

State File No.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 1088

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

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: City Sanitarium 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11yrs.1mo.20ds. (Specify whether
In this community 43 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 5400 Arsenal St. 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME HESTER SHELBY

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race white

6. (a) Single, widowed, married, divorced Div. 3

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased August (Month) 12 (Day) 1903 (Year)

8. AGE: Years 43 | Months 0 | Days 8 | If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Mgr. Parts Dp. Ford Automobile

11. Industry or business

FATHER
12. Name Alexander Monroe Shelby
13. Birthplace (City, town, or county) Kentucky (State or foreign country) 1

MOTHER
14. Maiden name Mattie Gream
15. Birthplace (City, town, or county) Kentucky (State or foreign country) 1

16. (a) Informant Clara Robinson

(b) Address 5400 Arsenal St.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug. 23 1946 (Month) (Day) (Year)

(c) Place: burial or cremation Mayfield, Kentucky.

18. (a) Signature of funeral director C. R. Lupton & Sons

(b) Address 7233 Delmar Blvd.

19. (a) AUG 22 1946 (Date received local registrar) J. J. Bredrick (Registrar's signature) 5

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 20 year 1946 hour 10.20 minute P M.

21. I hereby certify that I attended the deceased from May 1, 1946, to Aug. 20, 1946; that I last saw h im alive on August 20, 1946; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Empyema. right pleural cavity	
Due to: advanced	5 Or 6 weeks
Due to: Pneumonia -Bronchial	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations 110A

Of autopsy As above

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? (Specify type of place) 0

While at work (e) Means of injury

23. Signature Paul T. Hatton (M. D. or other) MD

Address 5400 Arsenal Date signed 8/21/46

(Licensed Embalmer's Statement on Reverse Side)

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 Raymond L. Mor

Licensed Embalmer No. 4330

P. O. Address Maplewood,

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.

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-45
K43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 314 Primary Registration District No. 1023 Registrar's No. 72 82

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Hester Shelby

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Div

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug 12 1900
(Month) (Day) (Year)

8. AGE: Years 43 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace
(City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (b) Date thereof
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Sept 16 (b) J. J. Bredenkamp
(Date received local registrar) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 14
year 1944 at hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

29064