

1. PLACE OF DEATH

MICHIGAN DEPARTMENT OF HEALTH

Division of Vital Statistics

CERTIFICATE OF DEATH

State Office No.

22518347

County Genesee

Township _____

Village _____

City Flint

(No. Hurley Hospital St. _____ Ward _____)
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Register No. 1146

2. FULL NAME Florence Ruth Sheldon

(a) Residence No. 1710 Maple Ave. Rd. St., Ward Flint

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. Color or Race White 5. Single, Married, Widowed or Divorced (WRITE the word) Divorced

5a. If married, widowed or divorced HUSBAND of (or) WIFE of Elmer

6. DATE OF BIRTH (Month, day and year) Sept. 29, 1874

7. AGE Years 61 Months 0 Days 8 IF LESS than 1 day hrs. OR min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTH PLACE (city or town) Mundy Twp. Genesee Co. Michigan

13. NAME George Baker

14. BIRTHPLACE (city or town) Devonshire England

15. MAIDEN NAME Betsy Ann Allen

16. BIRTHPLACE (city or town) Mundy Twp. Genesee Co. Michigan

17. INFORMANT Mrs. Mabel Johnson (Address) Flint, Michigan

18. BURIAL, CREMATION, OR REMOVAL Place Bristol Cemetery Date Oct. 9, 1935

19. UNDERTAKER Odds-Sumanois Co. (Address) Flint, Michigan, Mich.

20. FILED 10-9-35 L. A. Lambert, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) Oct. 7, 1935

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____
I last saw her dead Oct 7, 1935; death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Carcinoma of Left Breast
Metastasis of both lungs left ribs and Axilla

Other contributory causes of importance _____

If operation, date of _____ Condition for which performed _____ Organ or part affected _____

Was there laboratory test? _____ Autopsy? Yes
In case of violence state if accident, homicide or suicide No

Where did injury occur? Street near Home (Specify city, county or state)

In industry, home or public place? Home

Was disease or injury related to occupation of deceased? No

Signed Frank A. Warren, M.D. Registrar
Address 816 Union Industrial Bldg Flint Mich