

REC'D APR 17 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

9437  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township 1st mo Primary Registration District No. 1002 Registered No. 1043  
 (c) City St. Louis (d) Street No. M. C. DeWitt Hosp St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 1703 Guinette St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Eva Shockley  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept-12-1883  
 7. AGE YEARS 55 MONTHS 5 DAYS 2 If LESS than 1 day, hrs. or min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. St. Q. A.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER 13. NAME Thomas Shockley

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Missouri

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Physician M. C. DeWitt Hosp

18. BURIAL, CREMATION, OR REMOVAL Central Cem 3-10-39

19. FUNERAL DIRECTOR (ADDRESS) W. B. Campbell

20. FILED Mar 7 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-3-39  
 22. I HEREBY CERTIFY, That I attended deceased from 2-27-39, 19, to 3-3-39, 19, if I saw him live on 3-3-39, 19. Death is said to have occurred on the date stated above, at 8:59 a.m.  
 The principal cause of death and related causes of importance were as follows:

Bilateral Broncho Date of onset  
pneumonia; Coronary  
adenitis  
 Other contributory causes of importance:  
Chronic swelling liver  
and kidneys; Infarcts of spleen.

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....  
 If so, specify.....  
 (Signed) P. H. De Maria M. D.  
 (Address) St. Louis, Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.  
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**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.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.**