

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

Rev. 5-17-39  
1 X1931

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
JAN 12 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 41503  
Registrar's No. 10626

Registration District No. 791 Primary Registration District No. 1003

1. PLACE OF DEATH: 1003  
(a) County St Louis  
(b) City or town St Louis  
(c) Name of hospital or institution: DePaul Hospital  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_  
years, months or days

8. (a) PRINT FULL NAME Infant Of John & Shaughnessy  
8. (b) If veteran, name war \_\_\_\_\_  
8. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec 11 1939  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
Stillborn 0 0 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name John Shaughnessy  
13. Birthplace St Louis Mo  
14. Maiden name Mary Ellen Clarke  
15. Birthplace St Louis Mo

16. (a) Informant's own signature \_\_\_\_\_

(b) Address 5760 Vivian Ave

17. (a) Burial (b) Date thereof 12/12/39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Stroot - Carroll

(b) Address 4600 Natural Bridge Ave

19. (a) DEC 12 1939 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St Louis  
(d) Street No. 5760 Vivian Ave  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec day 11th  
year 1939 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from Stillborn  
\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on Stillborn \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Stillborn  
Due to 5 mo gestation  
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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature W. J. Newman (M. D. or other) M.D.  
Address 4126 1/2 Sherwin Date signed 12-12-39

Dr. Erdman 4126 Schenck

1:50 PM 3 R 14

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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 No Embalming.  
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.**