

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

Rev. 5-17-39
1 X 1111

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23720
Registrar's No. 6215

Registration District No. 791

Primary Registration District No. 1003

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;
Homer Phillips Hospital 1
(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 Mo. (b) County _____
(c) City or town St. Louis 21
(If outside city or town limits, write "RURAL")
(d) Street No. 2731 Market St
(If rural, give location)
(e) If foreign born, how long in U. S. A. no physician in attendance years.

3. (a) PRINT FULL NAME Cyril M. Shaw 000
(b) If veteran, name war World's War (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 21st
year 1940 hour 8 minute 45 P. M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex Male 5. Color or race Col
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Fannie Shaw 6. (c) Age of husband or wife if alive 30 years
7. Birth date of deceased Aug 1885
(Month) (Day) (Year)

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

8. AGE: Years at 54 Months _____ Days _____ If less than one day hr. _____ min. _____

Immediate cause of death _____
Due to Nephro-Sclerosis

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

Due to Cardiac Hypertrophy

10. Usual occupation Janitor
11. Industry or business _____
12. Name Unknown 9
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) _____
Major findings: JOI
Of operations _____
Of autopsy _____

16. (a) Informant's own signature Fannie Shaw
(b) Address 2731 Market St
17. (a) Burial (b) Date thereof 7-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Jefferson Burial Home
18. (a) Signature of funeral director McDonnell Funeral Home
(b) Address 3506 Franklin Ave
19. (a) Jul 25 1940 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Joseph J. ...
Address _____ Date signed _____

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.....

..... William C. McDowell, Registered Apprentice No.....
working under my personal supervision.

Signed..... William C. McDowell

Licensed Embalmer No..... 2114

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.