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V. S. No. 2
SOM-9-4-41
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **851**
Registrar's No. **948**

FILED FEB 24 1942
797

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Mo. 29 Days**
In this community **35 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3225 Montgomery St.**
(If rural, give location)
(e) Citizen of foreign country? **Yes** or No
If yes, name country.....

3. (a) PRINT FULL NAME **Charles Shaw**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **Male** 5. Color or race **White** 6. (a) ~~Single~~ **Widowed**, ~~Married~~ divorced **Widower**

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

7. Birth date of deceased **February 14, 1882**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 11 10 hr. min.

9. Birthplace **DeSoto, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Unknown**

11. Industry or business **----**

12. Name **Lafayette** 13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

14. Maiden name **Stella Bickford** 15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Margaret Burke**
(b) Address **1515 Lafayette**

17. **Anatomical Burial** Date of burial (Month) (Day) (Year) **1-29-42**
(Burial, cremation, or removal)

18. (a) Signature of funeral director **J. P. [Signature]**
(b) Address **1515 Lafayette**

19. (a) **JAN 30 1942** (b) **J. P. [Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **16**, year **1942** hour **10:50** minute **P.** M.

21. I hereby certify that I attended the deceased from **November 18, 1941** to **January 16, 1942**
that I last saw him alive on **January 16, 1942** and that death occurred on the date and hour stated above.

Immediate cause of death: **Chromobacterium obliterans & subsequent gangrene of right lower extremity**
Due to.....

Due to.....
Other conditions (Include pregnancy within 3 months of death).....

Major findings: **Amputation - mid thigh (gangrene of rt. lower extremity)**
Of operations..... Of autopsy.....

Duration **1 1/2 yrs. ? 8 mos. ?**

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).....
23. Signature **[Signature]** (M. D. or other).....
Address **1515 Lafayette Avenue** Date signed **1/27/42**

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

MOTHER FATHER

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, fact should be so stated above.