

FILED DEC 9 1943

318

Registration District No. _____

Primary Registration District No. _____

1003

Registrar's No. _____

10192

1. PLACE OF DEATH:

(a) County _____
(b) City or town Saint Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Saint Louis Maternity Hospital
(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)

3. (a) PRINT FULL NAME Infant Girl Shelley

3. (b) If veteran, name war _____ 3. (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 November 4, 1943
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 1 If less than one day 4 hr. 45 min.

9. Birthplace Saint Louis Miss Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Millard LeRoy Shelley
13. Birthplace Harrisburg Pennsylvania
(City, town, or county) (State or foreign country)
14. Maiden name Ethel Lydia Strickland
15. Birthplace Curwensville, Pennsylvania
(City, town, or county) (State or foreign country)

16. (a) Informant Saint Louis Maternity Hospital
(b) Address 630 So. Kingshighway Blvd.

17. Funeral Home (b) Date thereof 11-30-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington University

18. (a) Signature of funeral director W. Richter
(b) Address 3550 Rutger

19. (a) NOV 30 1943 (b) J. F. Bruesch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town Saint Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. 1715 Michigan Avenue
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day Sixth
year 1943 hour Four minute Forty A.M.

21. I hereby certify that I attended the deceased from 11/4, 1943 to 11/6, 1943;
that I last saw him alive on 11/6, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death: Fractures of tentorium cerebelli
intracranial hemorrhage. Duration 11/4

Due to Birth injury.

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy As above.

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 J. W. Vicary (M. D. or other) M.D.
Address 630 W. Kingshighway Date signed 11/6/43

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

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.