

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 5 1945
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11110**

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:
City Hosp. #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 hrs.
(Specify whether
In this community 30 Years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5309 N. Euclid Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Madge T. Shaffer

3. (b) If veteran, name war None 3. (c) Social Security No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lynn Shaffer 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased July 29, 1888
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>XX</u>	<u>4</u>	<u>25</u> hr. min.

9. Birthplace Quincy, Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Alvin House

13. Birthplace Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Cora Murphy

15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Lynn Shaffer

(b) Address 5309 N. Euclid Ave.

17. (a) Burial (b) Date thereof 12/29/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cem.

18. (a) Signature of funeral director [Signature]
(b) Address 2117 E. Grand Blvd.

19. (a) DEC 27 1944 J. F. Bredack
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 26
year 1944 hour 4 minute 15 A. M.

21. I hereby certify that I attended the deceased from Sept 15, 1944 to Dec. 26, 1944
that I last saw him alive on Dec. 25, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy
Due to arterio-sclerosis

Duration 6 hours
Don't know

Other conditions [Signature]
(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? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)
While at work? (c) Means of injury
23. Signature R. R. Meuron (M. D. or other) [Signature]
Address 330 Geraldine Ave Date signed 12/27/44

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. 3041

P. O. Address. 2117 E. Grand

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.