

FILED MAR 28 1945
1378

Registration District No.

Primary Registration District No.

1003

Registrar's No.

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: Barnes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... 17 days
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME MICHAEL JOHN SHARLEVILLE

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife..... Mazie Sharleville 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased..... November 7 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 4 8 hr. min.

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

10. Usual occupation Foreman

11. Industry or business.....

MOTHER FATHER { 12. Name..... Charles Sharleville
13. Birthplace..... Unknown Missouri
(City, town, or county) (State or foreign country)
14. Maiden name..... Mary Tellate
15. Birthplace..... Unknown Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant..... Mazie Sharleville
(b) Address..... Mitchell, Ill.

17. (a) Removal (b) Date thereof..... 3-16-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation..... Edwardsville, Ill.

18. (a) Signature of funeral director..... Albert H. Hoppe
(b) Address..... 4700 Washington Blvd.

19. (a) MAR 16 1945 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Illinois (b) County..... Madison
(c) City or town..... Mitchell
(If outside city or town limits, write "RURAL")
(d) Street No.....
(If rural, give location)
(e) Citizen of foreign country?..... 2 (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15
year..... 1945 hour..... 9 minute..... A. M.

21. I hereby certify that I attended the deceased from.....
Feb. 26 1945 to..... March 15 1945;
that I last saw him alive on..... March 15 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death..... Coronary failure Duration

Due to..... Arteriosclerotic Ht Disease
Hypertensive Cardiovascular Disease

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?.....
(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.....

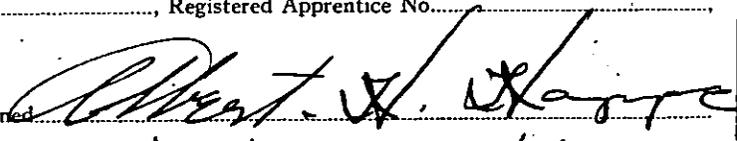
23. Signature..... John H. Eisenhower (M. D. or other)
Address..... Barnes Hospital Date signed..... 3-15-45

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.....

1861

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.