

No. 2
4-5-43
5-17-39
I X38671

FILED AUG 29 1946

Registration District No. 1 Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town VALLEY PARK MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Moth Nursing Home 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution From Dec. 17-1945
(Specify whether years, months or days) 45 yrs.

3. (a) PRINT FULL NAME LEALIE SHEAFOR

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife ANNA WALK SHEAFOR

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

7. Birth date of deceased JAN. 6 1869
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>7</u>	<u>5</u>	hr. _____ min. _____

9. Birthplace BERLINGTON, KAN.
(City, town, or county) (State or foreign country)

10. Usual occupation CARPENTER

MOTHER FATHER

11. Industry or business _____

12. Name Martin T. Sheafor

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

14. Maiden name unknown

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

16. (a) Informant Annice Sheafor

(b) Address 9521 Marlowe, Overland

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-46
(Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Thomas R. Bostick

(b) Address 2504 Thompson Rd.

19. (a) 8-14-46 (Date received local registrar) (b) C. J. M. Davant
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town OVERLAND 13
(If outside city or town limits, write "RURAL")

(d) Street No. 9521 MARLOWE 1
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 11th
year 1946 hour 11 minute 40 P.M.

21. I hereby certify that I attended the deceased from Dec. 14, 1945, to Aug. 12th, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death uremia

Due to Chronic valvular heart disease & nephritis

Due to Senility

Other conditions (Include pregnancy within 3 months of death) S.P.D.

Duration unknown

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Clara M. Selert (M. D. or other) MD

Address Valley Park, Mo. Date signed 8/14/46

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..... *Harold K. Brown*

Licensed Embalmer No. *4337*

P. O. Address..... *Overland, Mo*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Sept

Registration District No.

317

Primary Registration District No.

6076

Registrar's No.

1676

1. PLACE OF DEATH:

(a) County St Louis
 (b) City or town Valley Park
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(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 NAMELeahie Sheaffer3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex m 5. Color or race w 6. (a) Single, widowed, married,
divorced m6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased _____
(Month) (Day) (Year)8. AGE: Years Months Days (If less than one day)
77 hr. min.9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)16. (a) Informant _____
(b) Address _____17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____18. (a) Signature of funeral director _____
(b) Address _____19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____
year 1946 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____
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 Clara M. Beckers (M. D. or other) MD
Address Valley Park, Mo Date signed 9/24/46

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

MOTHER, FATHER

SUPPLEMENTARY

28370

one - year