

S. No. 2
OM-543
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3111

State File No. _____
405
Registrar's No. _____

FILED JAN 27 1947 318
Registration District No. _____

Primary Registration District No. 1003

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: DECONESS HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 DAYS
(Specify whether _____)
In this community 4 DAYS
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State ILLINOIS (b) County _____
(c) City or town NORRIS CITY
(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 _____

3. (a) PRINT FULL NAME FLORA P. SHEWMAKER

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 MARRIED
6. (b) Name of husband or wife CLOUD 6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased JUNE 20 1901
(Month) (Day) (Year)

8. AGE: Years 45 Months 6 Days 17 If less than one day _____ hr. _____ min.

9. Birthplace WHITE CO ILL.
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business HOME

12. Name DAVID HANOLD

13. Birthplace UNKNOWN
(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 MR CLOUD SHEWMAKER

(b) Address NORRIS CITY ILL.

17. (a) REMOVAL (b) Date thereof 1-10-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NORRIS CITY ILL.

18. (a) Signature of funeral director ROWLAND SERVICE

(b) Address 4355 WASHINGTON AV.

19. (a) JAN 14 1947 (b) J. J. Bredbeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JANUARY day 7
year 1947 hour 5 minute A M.
21. I hereby certify that I attended the deceased from Jan. 1, 1947
to January 6 inclusive 1947
that I last saw her alive on Jan. 6, 1947,
and that death occurred on the date and hour stated above.
Immediate cause of death Pneumonia Lobar Duration _____

Due to Empyema of gall bladder & liver abscesses.
Due to Cause of liver abscesses Not known

Other conditions (Include pregnancy within 3 months of death) 128

Major findings: Of operations _____

Of autopsy Empyema of gall bladder liver abscesses not known

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) (c) Means of injury _____

23. Signature Chaloner Howard M.D. (M. D. or other) _____
Address 607 N. Grand Date signed 1-9-47

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

20
17
9

99
NR
2

MOTHER FATHER

405

405

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..... *Alex Campbell*.....
Licensed Embalmer No..... *3880*.....
P. O. Address..... *St. Louis 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.