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

FILED OCT 23 1948

Registration District No. 3947

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution since 8/30/48
(Specify whether years, months or days) 27 years

3. (a) PRINT FULL NAME Leslie K. SHAFFER
3. (b) If veteran, name war World II
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 Margaret Shaffer
6. (c) Age of husband or wife if alive 24 years
7. Birth date of deceased October 21, 1920
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
27 10 27 hr. min.

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

10. Usual occupation Student

11. Industry or business

MOTHER FATHER {
12. Name Elmer W. Shaffer
13. Birthplace St. Francois Co Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Ethel Kimberlin
15. Birthplace Washington Co Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Registrar, Vet. Adm. Hospital

(b) Address Jefferson Barracks, Mo.

17. (a) Burial (b) Date thereof 9/20/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sullivan, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd

19. (a) 9-21-48 (b) Leslie K. Shaffer M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 36
(c) City or town Sullivan 4
(If outside city or town limits, write "RURAL")
(d) Street No. 234 Hobart 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 18
year 1948 hour 2:05 minute a. M.

21. I hereby certify that I attended the deceased from August 30, 1948, to September 18, 1948
that I last saw him alive on September, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolus Duration
Due to - 170-C-8
Due to - 8-18

Other conditions Fracture of Pelvis 8-30-48
(Include pregnancy within 3 months of death)

Major findings: Manipulation of Pelvis
Of operations 9/11/48
Of autopsy No 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) Accident 36
(b) Date of occurrence 8/30/48
(c) Where did injury occur? Near Stanton, Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public place

(Specify type of place) (e) Means of injury Automobile
While at work L.E. Stilwell
23. Signature L.E. STILWELL, M.D. (M. D. or other) 0
Chief, Professional Services
Address Vet. Adm. Hosp., Jefferson Barracks, Mo. Date signed 9-18-48

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. 3749

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.