

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

38871

State File No. _____
Registrar's No. 2629

Registration District No. 377

Primary Registration District No. 3063

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7551 Oxford Drive
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Martha Kate Shaw

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife William E. Shaw 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 9, 1875
(Month) (Day) (Year)

8. AGE: Years 73 Months 5 Days - If less than one day _____ hr. _____ min.

9. Birthplace Carlinville, Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business Housewife

12. Name John W. McNeill
13. Birthplace Danville, Ky.
(City, town, or county) (State or foreign country)
14. Maiden name Mary E. Taggart
15. Birthplace Carlinville, Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. H. McCaughan

(b) Address 7551 Oxford Drive

17. (a) Removal (b) Date thereof 11/11/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jacksonville, Florida

18. (a) Signature of funeral director Robert J. Ambruster, Inc.

(b) Address Clayton Rd. at Concordia Lane

19. (a) 11-10-48 (b) Cecil J. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Clayton
(If outside city or town limits, write "RURAL")
(d) Street No. 7551 Oxford Drive.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 9
year 1948 hour 5 minute 45 P.M.

21. I hereby certify that I attended the deceased from 7/2/48, 19____, to Nov. 9, 1948
that I last saw h. or alive on November 9, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Acute leukemia Duration 4 yrs

Due to toxic depression of bone marrow (chronic in bone marrow biopsy)

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

Major findings: _____
Of operations _____
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) _____
(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 fall

23. Signature [Signature] (Dr. P. or other)
Address 3601 Washington Blvd. Date signed 11/10/48

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

MOTHER FATHER

6
2
3

48

REC'D
20
1948

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 Ernest W. Spillers

Licensed Embalmer No. 14080

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.