No. 300
10.48

NR

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

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6682

BIRTH NO. 49-005009 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1860

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS
c. LENGTH OF STAY (in this place): 0
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. LOUIS MATERNITY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: 107
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SUCCESS RURAL RT. 0
d. STREET ADDRESS (If rural, give location): 0

3. NAME OF DECEASED (Type or Print)
a. (First): INFANT
b. (Middle): SHACKLETTE
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): JANUARY 26 49

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 0

8. DATE OF BIRTH: JANUARY 26 49

9. AGE (In years last birthday): IF UNDER 1 YEAR Months: Days; IF UNDER 24 HRS. Hours: Min. 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): ST. LOUIS, MISSOURI 0

12. CITIZEN OF WHAT COUNTRY?:

13a. FATHER'S NAME: THOMAS DELMAR SHACKLETTE

13b. MOTHER'S MAIDEN NAME: MARJORIE MARIE FOSTER

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S SIGNATURE OR NAME ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Erythroblastosis Foetalis

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Jan-26, 1949, *to* Jan 26, 1949, *that I last saw the deceased alive on* Jan-26, 1949, *and that death occurred at* 9 45 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. J. Harch M.D.

23b. ADDRESS:

23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify):

24b. DATE: FEB 28 1949

24c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

24d. LOCATION (City, town, or county) (State):

DATE REC'D BY LOCAL REG.: FEB 28 1949

REGISTRAR'S SIGNATURE: J. B. Lassater

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rowland Mort Service - 4104 Manchester

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Student Embalmer No. .....,

working under my personal supervision.

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

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.