No. 300
10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 275 25676

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 4465 Registrar's No. 2759

1. PLACE OF DEATH
a. COUNTY: St. Louis 4001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rock Hill
c. LENGTH OF STAY (In this place): 11 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rock Hill Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2129
d. STREET ADDRESS (If rural, give location): 5500 Pershing

3. NAME OF DECEASED (Type or Print)
a. (First): May
b. (Middle): M.
c. (Last): Shryock

4. DATE OF DEATH (Month) (Day) (Year): 7 24 51

5. SEX: F
6. COLOR OR RACE: M
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 24 1869
9. AGE (In years last birthday): 82 — If under 1 year: Months 0, Days 0; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nil
10b. KIND OF BUSINESS OR INDUSTRY: ✓
11. BIRTHPLACE (State or foreign country): St. Louis Mo
12. CITIZEN OF WHAT COUNTRY?: U.S.
13a. FATHER'S NAME: Leicester McMachen
13b. MOTHER'S MAIDEN NAME: Maria Davis
14. NAME OF HUSBAND OR WIFE: Ira Shryock (Dec)
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: Mrs. Alice Herman #4 Wickersham Dr.

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): Cerebral hemiplegia
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis
DUE TO (c): 334X
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Chronic myocarditis

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* July 21, 1951, *to* July 24, 1951, *that I last saw the deceased alive on* July 23, 1951, *and that death occurred at* 11:45 PM m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. Merklin M.D.
23b. ADDRESS: 3507 Potomac
23c. DATE SIGNED: 7-24-51
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/25/51
24c. NAME OF CEMETERY OR CREMATORY: Bellefontaine Cem.
24d. LOCATION (City, town, or county) (State): St. L. Mo
DATE REC'D BY LOCAL REG.: 7-24-51
REGISTRAR'S SIGNATURE: Hubert R. Donks M.D.
25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS: Louis H. Bippe Inc. Kirkwood
(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

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

working under my personal supervision.

Student .....
Student Embalmer

Signed Felix Durand

Licensed Embalmer No. 3034

P. O. Address Kirkwood 22

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.