

REGISTRATION DISTRICT NO. 317

PRIMARY REGISTRATION DISTRICT NO. 6076

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Overland
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
8645-Argyle Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 117 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Overland
(If outside city or town limits, write "RURAL")
(d) Street No. 8645-Argyle Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Ballard B. Shifflet

3. (b) If veteran, name war None 3. (c) Social Security No. 198-06-3830

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Clara M 6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased Jan 19 1879
(Month) (Day) (Year)

8. AGE: Years 64 Months 8 Days 28 If less than one day hr. min.

9. Birthplace Harris Station Ky.
(City, town, or county) (State or foreign country)

10. Usual occupation Parking lot Attendant

11. Industry or business Medical Arts Building

12. Name John Shifflet
13. Birthplace Ky.
(City, town, or county) (State or foreign country)
14. Maiden name Emma Gilan
15. Birthplace Ky.
(City, town, or county) (State or foreign country)

16. (a) Informant Clara M. Shifflet
(b) Address 8645-Argyle Ave-Overland, Mo.

17. (a) Burial (b) Date thereof 10-20-1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Blair...
(b) Address 2504-Woodson Rd-Overland, Mo.
OCT 20 1943

19. (a) OCT 20 1943 (b) C. M. Shifflet
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17
year 1943 hour 5 minute 30 A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Natural causes. Duration _____
Due to Coronary sclerosis.
Due to _____

Other conditions (include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy Yes. 942
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 ?
23. Signature H. S. ... Deputy Coroner
Address Kirkwood, Mo. 1818-43 Date signed _____

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

MOTHER FATHER

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

Oscar F. Mueller

Licensed Embalmer No. *3039*

P. O. Address *Overland 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.