

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

ED JUN 14 1943 318

1003

Registrar's No. 5260

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:

(a) County..... St. Louis, Missouri

(b) City or town..... St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... 12 Days
(Specify whether Life)

In this community..... Life
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County..... St. Louis

(c) City or town..... St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4471 Laclode Avenue
(If rural, give location)

(e) Citizen of foreign country?..... No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Mary Shifflette

3. (b) If veteran, name war No 3. (c) Social Security No. Unknown

4. Sex. Female 5. Color or race White 6. (a) Single, widowed, married, divorced. Married

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive. Unknown years

7. Birth date of deceased..... February 12, 1868
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2, year 1943 hour 9:40 minute P. M.

21. I hereby certify that I attended the deceased from May 22, 1943 to June 2, 1943 that I last saw her alive on June 2, 1943 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>3</u>	<u>21</u>hr.min.

Immediate cause of death:
Chronic myeloid leukemia
non-calculeous

Due to meninges

Due to ovarian cyst

Other conditions.....
(Include pregnancy within 3 months of death) St

9. Birthplace..... St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation..... Nil.

11. Industry or business..... Nil.

Major findings:
Of operations.....

Of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER { 12. Name Unknown Woodfin

FATHER { 13. Birthplace..... Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace..... Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant..... Wm P Morris
(b) Address..... St. Louis City Hospital.

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?

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-8-43
(Month) (Day) (Year)

(c) Place: burial or cremation..... CALVARY

18. (a) Signature of funeral director..... Callen Kelly
(b) Address..... 1416 N. TAYLOR AVE

19. (a) 6/7 (Date received local registry) (b) J. F. Prudeck (Registrar's signature)

While at work?..... (Specify type of place)

23. Signature..... Drewson Petersen (M. D. or other)
Address..... 1515 Lafayette Avenue. Date signed..... 6/3/43

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 James A. Lammers
Licensed Embalmer No. 4142
P. O. Address St. Louis

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.