WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. 791 File No. 25771

Township..... Primary Registration District No. 1003 Registered No. 7374

City St Louis (No. 5839a Easton Ave St. ..... Ward)

2. FULL NAME Orison H. Shores

(a) Residence. No. 5839a Easton Ave St., 6 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5A. IF MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~ HUSBAND OF (OR) ~~WIFE~~ OF Grace Shorer.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 28 - 1859

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	67	8	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engraver (retired)

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Waverly
(STATE OR COUNTRY) Iowa.

PARENTS

10. NAME OF FATHER William Shorer

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ?
(STATE OR COUNTRY) Penn.

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY) Don't know.

14. INFORMANT Mrs. Grace Shorer
(Address) 5839a Easton Ave.

15. FILED AUG 16 1927 19 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 14 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at 7 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Haemorrhage

Apoplexy

N. M. A. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 74 a

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed) H. W. Fack M.D.

8/16, 1927 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Valhalla Cemetery. DATE OF BURIAL 8-16 1927

20. UNDERTAKER Geo. L. Pleitsch ADDRESS 5966 Easton Ave

Dr. C. C.
3870 Easton Ave.