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

Do not use this space.

38778

File No. 11509

Registered No.

1. PLACE OF DEATH

County

Township

City St. Louis (No. City Hospital #2 St. Ward)

Registration District No. 791

Primary Registration District No. 1903

2. FULL NAME Herman Shaw

(a) Residence. No. 3222 Pine St., 21 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Col.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) ~~WIFE OF~~: Geldie Shaw

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 6 1891

7. AGE: Years 36 | Months 7 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Texas

PARENTS

10. NAME OF FATHER: Jim Shaw

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Texas

12. MAIDEN NAME OF MOTHER: Grace Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Texas

14. INFORMANT: Anna F. Woodard
(Address): City Hospital #2

15. FILED DEC 23 1927, 19..... Mae C. Starkeo
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec. 18, 1927

17. I HEREBY CERTIFY, That I attended deceased from 11/28, 1927, to 12/18, 1927, that I last saw h. alive on 12/18, 1927, and that death occurred, on the date stated above, at 1:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
~~Bronchial Pneumonia~~
936
10/27
Alcoholism (duration) yrs. mos. ? ds.

CONTRIBUTORY (SECONDARY): Chr. myocarditis
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) L. B. Handly, M. D.
19 (Address) City Hosp. #2

*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: St. Peters Cemetery

DATE OF BURIAL: 12/24 1927

20. UNDERTAKER: E. E. Pettis

ADDRESS: 3030 Belle

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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD