

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.

OCT 2 1936

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

Do not use this space.

1. PLACE OF DEATH

County.....  
Township.....  
City..... *St. Louis, Mo.*

Registration District No. **791**  
Primary Registration District No. **1003**  
(No. *Barnes Hospital*)

File No. **32909**  
Registered No. **8791**  
St. .... Ward)

2. FULL NAME

*Charles August Shadle*  
(a) Residence, No. .... St. *N.R.* Ward. *Du Bois Ill*  
(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 *M* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Dec 6 1893*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
*42* ... *8* ... *17*

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Miner*  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Du Bois Ill.*

FATHER 13. NAME *Lawrence Shadle*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Sandoval Ill.*

MOTHER 15. MAIDEN NAME *Augusta Kroeger*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

17. INFORMANT (ADDRESS) *Augusta Shadle Du Bois Ill.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Chapel Hill Du Bois Ill.* DATE *8-26-36*

19. UNDERTAKER (ADDRESS) *Albert H. Hoppe Inc 429 N. Main St. St. Louis*

20. FILED **AUG 24 1936** *J. F. Bredeck Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *8-23* 19*36*

22. I HEREBY CERTIFY, That I attended deceased from *8-4* 19*36*, to *8-23* 19*36*

I last saw him alive on *8-23* 19*36*. Death is said to have occurred on the date stated above, at *12 P.M.*

The principal cause of death and related causes of importance were as follows:

*Stricture of oesophagus  
Perforation of oesophagus  
Retroperitoneal Abscess  
Empyema, bilateral  
Cause of abscess unknown*

Other contributory causes of importance:  
*III*

Name of operation *Oesophagoscopy* Date of *8-23-36*  
What test confirmed diagnosis? *GASTROSCOPY* Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury  
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? *No*  
If so, specify  
(Signed) *W. Russell Smith, M. D.*  
(Address) *Barnes Hospital*

