

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

32683

Do not use this space.

1. PLACE OF DEATH

(a) County

Registration District No.

(b) Township

Primary Registration District No.

(c) City

(d) Street No.

En route City Hospital #1

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred

(f) How long in U. S., if of foreign birth?

2. PRINT FULL NAME

(a) Residence, No.

4153 McPHERSON

St.

19

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

MALE

4. COLOR OR RACE

WHITE

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

MARRIED

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

MINNIE SHAW

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

MAY 1, 1863

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ... hrs. or min.

74

4

14

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

FURNACE BUILDER

9. Industry or business in which work was done, as 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)

KOKOMO

INDIANA

13. NAME

MARION SHAW

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

KOKOMO

INDIANA

15. MAIDEN NAME

ANNA WILSON

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

KOKOMO

INDIANA

17. INFORMANT (ADDRESS)

MRS. MINNIE SHAW

4153 McPHERSON

18. BURIAL, CREMATION, OR REMOVAL

PLACE MEMORIAL PARK DATE 9-18 1937

19. FUNERAL DIRECTOR (ADDRESS)

MULLEN BROS.

4259 LINDELL BLVD

20. FILED

SEP 18 1937

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

9/15/37

19

22. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....

I last saw him alive on 19..... Death is said

to have occurred on the date stated above, at 8:15 P.M.

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

Date of onset

Shock and Injuries. Body crushed, suffered when he jumped from the Municipal Bridge, on Sept. 15, 1937, at about 8:15 P.M.

Other contributory causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide Suicide Date of injury 9/15, 1937

Where did injury occur? St. Louis, Mo.

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

In Public Place

Manner of injury

See Above

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed)

(Address)

STATEMENT BY LICENSED EMBALMER

I, H. E. Burgess, Licensed Embalmer No. 3547
hereby certify that the body recorded on the reverse side of this certificate was embalmed by myself
..... L. E.
No. or by Registered Apprentice No.
working under my personal supervision.
Signed H. E. Burgess
Licensed Embalmer No. 3547

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.)