

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.

REC'D SEP 12 1938  
 H. H. H. H. H.

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

Do not use this space.

791  
 1003

27743

PLACE OF DEATH

County ..... Registration District No. ....  
 Township ..... Primary Registration District No. ....  
 City St. Louis Children's Hospital St. .... Ward) .....

2. FULL NAME Shirley Jean Force 1020  
 (a) Residence, No. 424 Adelia St. NR Ward. Springfield, 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Child  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-12-37  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min. 1 0 19  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. ....  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .... Child  
 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) Springfield Ill.

FATHER 13. NAME CLARENCE

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

MOTHER 15. MAIDEN NAME Alma Weerts

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

17. INFORMANT J. Mc I Levin  
 (ADDRESS) 505 S. Kings highway

18. BURIAL, CREMATION, OR REMOVAL PLACE Raymond, Ill. DATE Sept. 2, 1938

19. UNDERTAKER Albert H. Hoppe, Inc.  
 (ADDRESS) 429 W. Euclid, Ave.

20. FILED Aug 31 1938  
J. J. Buchholz Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-31-38, 19

22. I HEREBY CERTIFY, That I attended deceased from 7-27-38, 19, to 8-31-38, 19.

I last saw h. s. r. alive on 8-31-38, 19. Death is said to have occurred on the date stated above, at 3:55 a. m.

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

Hydrocephalus, Congenital  
 Date of onset May '38

Other contributory causes of importance:

Name of operation Choroid plectomy Date of 8-30-38  
 What test confirmed diagnosis? ..... 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) Emmett B. Drescher, M. D.  
 (Address) 5005 King highway

Com blank signed  
CF