

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

30958  
 Do not use this space.

1. PLACE OF DEATH **DEC'D OCT 1 2 1938**

(a) County ..... Registration District No. **791**  
 (b) Township ..... Primary Registration District No. **1008**  
 (c) City **St. Louis** (d) Street No. **City Hospital No. 1** St. \_\_\_\_\_  
 (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 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.  
**D. 8110**  
**Cal Shaffner** / 76  
**City Hospital st. No. 1** 23  
 (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) **single**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **March 23, 1878**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**60**      **5**      **28** **14**

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. **porter**  
 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) **Unknown**  
**New York**

FATHER  
 13. NAME **Cal Shaffner**  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**  
**Virginia**

MOTHER  
 15. MAIDEN NAME **Unknown**  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**  
**Unknown**

17. INFORMANT (ADDRESS) **Hosp. Info M. Kent**  
**City Hospital #1.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Lake Charles, Cem** DATE **Sept. 21/ 1938**

19. FUNERAL DIRECTOR (ADDRESS) **Albert H. Hoppe, Inc.**  
**4700 Washington, Ave.**

20. FILED **26 1938** **J. J. Bredeck** Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **9/7/38** 19 **38**

22. I HEREBY CERTIFY, That I attended deceased from **9/2/38** to **9/7/38**, 19 **38**  
 I last saw him **9/7/38**, 19 **38** Death is said to have occurred on the date stated above, at **5.40 a.**  
 The principal cause of death and related causes of importance were as follows:  
**Carcinoma of Rectum**  
**Hemorrhage from Rectum**  
 Date of onset

Other contributory causes of importance:  
**Hemorrhage from Rectum**

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? **Biopsy** Was there an autopsy? **yes**

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? \_\_\_\_\_  
 If so, specify (Signed) **David Heiner**, M. D.  
 (Address) **City Hospital No. 1**

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.

8398  
8398

5381

STATEMENT BY LICENSED EMBALMER

I, Raymond E. Gerke, Licensed Embalmer No. 3985

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 Raymond E. Gerke  
Licensed Embalmer No. 3985

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.)

city license #99