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.

Registered FEB 13 1939

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

791
1003

4962
Do not use this space.

Registered No. 1655

1. PLACE OF DEATH

(a) County ..... Registration District No. 1003

(b) Township ..... Primary Registration District No. .....

(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. 14568

2. PRINT FULL NAME 160 Nellie Shaiper

(a) Residence, No. 1610 Semple St. 6
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
female	white	widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 17, 1877

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
61	7	8	

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. nil

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) Illinois 3

FATHER

13. NAME Quinn Shaiper

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

MOTHER

15. MAIDEN NAME Ellen Mc Dermott 5

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

17. INFORMANT (ADDRESS) Hosp. Info M. Kent

18. BURIAL, CREMATION, OR REMOVAL
PLACE Carlinville Ill. DATE Feb. 22, 1939

19. FUNERAL DIRECTOR (NAME) Albert H. Hoppe Inc.
(ADDRESS) 4700 Washington Blvd.

20. FILED FEB 20 1939, 19 J. F. Bredick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/18/39, 19

22. I HEREBY CERTIFY, That I attended deceased from 1/6/39, 19..., to 2/18/39, 19...
I last saw her alive on 2/18/39, 19... Death is said to have occurred on the date stated above, at 8.10 a. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis general	
nephrosclerosis & chronic	
nephritis in type.	

Other contributory causes of importance:
old minimal tuberculosis (Inactive) (Healed)

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... 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) L. P. Rel, M. D.
(Address) City Hospital No. 1

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Guy W Wilkinson

Licensed Embalmer No. 3575

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.