

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**

REC'D JUN 12 1939

17355  
Do not use this space.  
4889

**1. PLACE OF DEATH**

(a) County.....2 Registration District No.....791  
 (b) Township..... Primary Registration District No.....1008 Registered No.....  
 (c) City.....St. Louis (d) Street No.....5526 Pershing 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.

**2. PRINT FULL NAME** Samuel P. Shriber

(a) Residence, No. 5526 Pershing St. 12 (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Julia Shriber</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan. 1, 1859</u>		
7. AGE YEARS <u>80</u>	MONTHS <u>4</u>	DAYS <u>27</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Fur dealer</u>		
9. Industry or business in which work was done, as saw mill, bank, etc. <u>Retired</u>		
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) <u>Lake Providence Louisiana</u>		
FATHER	13. NAME <u>Samuel Shriber</u>	
FATHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>	
MOTHER	15. MAIDEN NAME <u>Bella Paradise</u>	
MOTHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mississippi</u>	
17. INFORMANT (ADDRESS) <u>Joseph Shriber 5805 Pershing</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>New Lit. Sinai</u> DATE <u>5/30</u> 19 <u>39</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>H. B. Berger 4715 McPherson</u>		
20. FILED <u>MAY 29 1939</u>		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 28 1939

22. I HEREBY CERTIFY That I attended deceased from April 7 1939, to May 28 1939  
 I last saw him alive on May 28 1939. Death is said to have occurred on the date stated above, at 11:05 P. m.  
 The principal cause of death and related causes of importance were as follows:  
Uraemia, Pernicious Anemia, Chronic Interstitial Nephritis, Arterio-Sclerosis

Other contributory causes of importance:  
Faulty Dentistry

Name of operation None Date of.....  
 What test confirmed diagnosis? Clinical Was there an autopsy? No

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) Jacob A. Hartmann, M.D.  
 (Address) 644 Anthony Bldg.

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**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.....

..... Herbert I. Berger ....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....



Licensed Embalmer No. 1597.....

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.**