

AUG 11 1939 791

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH: 1939 1003
(a) County _____
(b) City or town St. Louis.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4471 Olive Street.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 30 Years. years, months or days

3. (a) PRINT FULL NAME Ruth Dorothy Shadow. 30-2
8. (b) If veteran, name war _____ 8. (c) Social Security No. 497-07-9725

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Clarence Shadow. 6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased Dont Know. 1909
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
ART. 30 Dont Know. hr. min.

9. Birthplace Mo. (City, town, or county) (State or foreign country)

10. Usual occupation MILLINER

11. Industry or business _____

MOTHER FATHER { 12. Name Charles O. Howard.

18. Birthplace Mo. (City, town, or county) (State or foreign country)

14. Maiden name Dont Know.

15. Birthplace Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Clarence Shadow

(b) Address 4471 Olive St.

17. (a) Burial (b) Date thereof Aug. 1, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur O. Donnelly
(b) Address 3840 Lindell Blvd.

19. (a) JUL 31 1939 (b) J. B. Beckwith
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County _____
(c) City or town St. Louis. (If outside city or town limits, write "RURAL")
(d) Street No. 4471 Olive Street. (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 30th.
year 1939 hour 4.00 minute _____ A. M.

21. I hereby certify that I attended the deceased from July 25, 1939 to July 30, 1939; that I last saw h alive on July 24, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration 2 1/2 hrs

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury 1

23. Signature J. B. Beckwith (M. D. or other) _____
Address 415 1/2 Washington Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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.

4503 Woodlawn
10-11

STATEMENT BY LICENSED EMBALMER 111111

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 *Stanley Marshall*

Licensed Embalmer No. *2868*

P. O. Address. *3840 Lindell*

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.