

Registration District No. 791

Primary Registration District No. 1003

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(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: Homer G. Phillips Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 days
(Specify whether)

In this community 34 years
years, months or days

3. (a) PRINT FULL NAME Macie Shaw

3. (b) If veteran, name war No

3. (c) Social Security No. Mil

4. Sex Fem 5. Color or race Col

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Henry Shaw

6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased October 20, 1868
(Month) (Day) (Year)

8. AGE: Years 72 Months 5 Days 11 If less than one day
hr. min.

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

10. Usual occupation Mil

11. Industry or business _____

MOTHER FATHER

12. Name Tom Brown

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Winnie (Unknown)

15. Birthplace Shelby County Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Amelia Shaw

(b) Address 2718 Walnut St.

17. (a) Burial (b) Date thereof 4/5/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director [Signature]

(b) Address 3517 De la Salle Ave

19. (a) APR - 4 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 2718 Walnut
(If rural, give location)

(e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31
year 1941 hour 3:15 minute A. M.

21. I hereby certify that I attended the deceased from March 13, 1941 to March 31, 1941
that I last saw her alive on March 31, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Sclerosis

Duration Indef.

Due to _____

Due to _____

Other conditions [Signature]
(Include pregnancy within 3 months of death)

Major findings: [Signature]
Of operations _____

Of autopsy [Signature]

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

23. Signature [Signature] (M. D. or other) _____

Address 2601 N. Whittier Date signed _____

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed *W. M. Green*.....

Licensed Embalmer No. *1173*.....

P. O. Address *3517 S. Colorado Ave*.....

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12541
Registrar's No. 2971-

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Maie Shaw
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 8-7-41 (b) JF Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 31 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral, Arteriosclerosis
cerebral arteriosclerosis Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 97

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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?

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

