V. S. No. 2
50M—5-42
Rev. 5-17-39
X3287

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 6 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15544 /

Registration District No. 927 — Primary Registration District No. 6076 — Registrar's No. 817

1. PLACE OF DEATH:
(a) County: St. Louis County
(b) City or town: Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Adm. Jan. 7, 1943. (Specify whether years, months or days)
In this community unknown.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: 12
(c) City or town: St. Louis (If outside city or town limits, write "RURAL")
(d) Street No.: 4234a Easton Avenue (If rural, give location)
(e) Citizen of foreign country? - (Yes or No) /
If yes, name country -

3. (a) PRINT FULL NAME: Jesse Shanklin
3. (b) If veteran, name war: World War #1
3. (c) Social Security No.: Yes - not remembered.
4. Sex: Male
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Effie
6. (c) Age of husband or wife if alive: 38 years
7. Birth date of deceased: July (Month) 1. (Day) 1897 (Year)
8. AGE: Years 45 Months 9 Days 1 If less than one day hr. min.
9. Birthplace: Clarksville, (City, town, or county) Tennessee / (State or foreign country)
10. Usual occupation: Maintenance Man
11. Industry or business: -
FATHER
12. Name: Lucien Shanklin
13. Birthplace: Kentucky / (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Lelia Jones
15. Birthplace: Kentucky / (City, town, or county) (State or foreign country)
16. (a) Informant: M. Schulley
(b) Address: Clinical Clerk, VAF, Jeff. Bks., Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/6/43 (Month) (Day) (Year)
(c) Place: burial or cremation: Jeff. Bks, Mo.
18. (a) Signature of funeral director: R. M. C. Green
(b) Address: 3517 Laclede Avenue
19. (a) APR 6 1943 (Date received by local registrar) (b) C. L. McCarron M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2nd, year 1943 hour 3:30 minute A. M.
21. I hereby certify that I attended the deceased from January 7, 1943 to April 2nd, 1943; that I last saw him alive on April 2nd, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive and coronary arteriosclerotic heart disease with marked cardiac enlargement, myocardial damage and insufficiency. — Duration: Unknown

Due to: -

Other conditions: Arteriosclerosis, general, including cerebral arteriosclerosis with psychosis.
(Include pregnancy within 3 months of death)

Major findings:
Of operation: No operation.
Of autopsy: No 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): no
(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: L. M. COCHRAN, M.D. (M. D. or other)
Address: Chief Medical Officer Date signed: 4/2/43

(Licensed Embalmer's Statement on Reverse Side)

MAR 1 1944

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 [signature]

Licensed Embalmer No. 1173

P. O. Address 3517 Sackdale 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.