

FILED JUL 3 1943 318

Registration District No.

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County
(b) City or town **St. Louis**
(c) Name of hospital or institution: **Homer G. Phillips Hospital**
(d) Length of stay: In hospital or institution **4 Days**
In this community **0** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000 2**
(c) City or town **St. Louis**
(d) Street No. **1929 Papin St.**
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Lamarris Shaw**

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **0**

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

7. Birth date of deceased **June 4 1943**
(Month) (Day) (Year)

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

9. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name **Willie Shaw**
13. Birthplace **Memphis Tennessee**
14. Maiden name **Eva Perry**
15. Birthplace **Starkville Mississippi**

16. (a) Informant **Ethel M. Shepard**
(b) Address **2601 N. Whittier St.**

17. (a) **Burial** (b) Date thereof **JUN 24 1943**
(c) Place: burial or cremation **CITY CEMETERY**

18. (a) Signature of funeral director **H. Merschman**
(b) Address **City Health Dept**

19. (a) **JUN 24 1943** (b) **J. F. Boush**
(Date received local health officer's report) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **June** day **8**
year **1943** hour **8** minute **45a** M.

21. I hereby certify that I attended the deceased from **6-4**
6-8 19 **43** to **6-8** 19 **43**
that I last saw **her** alive on **6-8** 19 **43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Prematurity**

Due to **Unknown**

Due to **Unknown**

Other conditions (Include pregnancy within 3 months of death)

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?

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

23. Signature **E. Dickerson** (M. D. or other) **0**
Address **2601 N. Whittier** Date signed **6-22-43**

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

00
17
9

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.....

Licensed Embalmer No.....

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, fact should be so stated above.