

FILED JUL 13 1943

Registration District No.

Primary Registration District No.

Registrar's No. 6942

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution: Barnes Hospital
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Madison
(c) City or town Nameoki Township
(d) Street No. 3126 West Point Pl.
(e) Citizen of foreign country?.....
If yes, name country.....

3. (a) PRINT FULL NAME Ancil Harper Showers

3. (b) If veteran, name war World War 1 3. (c) Social Security No.....

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Married

6. (b) Name of husband or wife Olga Showers 6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased Aug. 8th, 1884
(Month) (Day) (Year)

8. AGE: Years 58 10 22 If less than one day 11 7 hr. min.

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

10. Usual occupation Special Agent
Burlington Railroad

MOTHER FATHER

11. Industry or business
12. Name Unknown
13. Birthplace Unknown
14. Maiden name Unknown
15. Birthplace Unknown

16. (a) Informant Mrs. Olga Showers
(b) Address 3126 West Point Pl.

17. (a) Burial (b) Date thereof July 2, 1943
(c) Place: burial or cremation East St. Louis, Ill.

18. (a) Signature of funeral director John J. Kassly
(b) Address 1101 N. 9th, East St. Louis, Ill.

19. (a) Jul 2 1943 (b) J. F. Polesak
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 30th day June
year 1943 hour 2:30 minute A. M.

21. I hereby certify that I attended the deceased from.....
that I last saw him..... alive on.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Cerebral Apoplexy;

Due to.....
Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

Duration

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.....
Where did injury occur?.....
(c) (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 Alfred J. Perry (M. D. or other)
Address Deputy Coroner Date signed 7/2/43

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

20
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.....

Not Embalmed

....., Registered Apprentice No.

working under my personal supervision.

Signed

John J. Karsky

Licensed Embalmer No. *6855*

P. O. Address *1101 5th St*

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.