

FILED FEB 11 1944 **B18**

State File No.

Registration District No. Primary Registration District No. **1002** Registrar's No. **1032**

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:
DePaul Hospital 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. **3 weeks.**
 (Specify whether
 In this community.....
 years, months or days)

3. (a) PRINT FULL NAME **Shelby H. Curlee**
 3. (b) If veteran, name war..... 3. (c) Social Security No. **491-14-4131**

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

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

7. Birth date of deceased. **August 29 1868**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 5 2 hr. min.

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

10. Usual occupation **Chairman of Board Curlee Clothing Co.**

11. Industry or business **William Peyton Curlee**

12. Name **William Peyton Curlee**

13. Birthplace **Marshall County Miss.**
 (State or foreign country)

14. Maiden name **Mary Boone**

15. Birthplace **Fayette County Tenn.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **F. M. Curlee**

(b) Address **1810 Boatman's Bank Bldg.**

17. (a) **Removal** (b) Date thereof: **2/1/44**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. **Corinth, Miss. Wagoner Mortuary**

18. (a) Signature of funeral director. **4161 Lindell Blvd.**

(b) Address **4161 Lindell Blvd.**

19. (a) **FEB 1 1944** (b) **J. F. Braden**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **St. Louis**
Florissant
 (c) City or town.....
 (If outside city or town limits, write "RURAL")
 (d) Street No..... (If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country **1**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **31** year **1944** hour **11** minute **20** p.M.

21. I hereby certify that I attended the deceased from **Oct 14**, 19**43**, to **Jan 31**, 19**44**; and that death occurred on the **Jan 30**, 19**44**; at **11:20** and hour stated above.

Immediate cause of death **Hypernephroma with metastases**

Due to.....
 Due to..... **52**

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

Major findings:.....
 Of operations.....

Of autopsy **Hypernephroma with metastases**

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.....

3. Signature **Samuel Grant** (M. D. or other) **M.D.**
 Address **114 N. Taylor** Date signed **2/1/44**

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

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

MOTHER FATHER

FLX

(Licensed Embalmer's Statement on Reverse Side)

Dr. Saul P. Grant
11 Taylor Ave.

FEB 10 1945

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.....

Melvin L. Kemper

Licensed Embalmer No. *4052*

P. O. Address *4005 Spring*

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. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 1032

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:
dde Paal
(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 Shelby H. Curlee

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased August 29 - 1884
(Month) (Day) (Year)

8. AGE: Years 75 Months 5 Days 2 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) MAR 24 1944 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. Chase Hotel - 212 N. Kingshighway
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No) Yes
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31
year 1944 hour _____ minute _____ M.

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

Duration _____

Due to _____

Due to _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTAL

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