

FILED MAY 25 1944

Registration District No. **218**

Primary Registration District No. **1003**

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: **St. John's Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **7 Days**
(Specify whether)

In this community **7 Days**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**

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

(d) Street No. **6024a Leona**
(If rural, give location)

(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Bertha Shipley**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **13** year **1944** hour **2** minute **15 P.M.**

4. Sex **Female**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **Tolbott G.**

6. (c) Age of husband or wife if alive, years **15** 1877
(Month) (Day) (Year)

7. Birth date of deceased **Feb.** **15** **1877**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **5/9/44**, 19... to **5/13/44**, 19...; that I last saw him alive on **5/13/44**, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death **Nephritis (acute)**

Duration **3 wks**

Due to **(C)**

Due to **130**

8. AGE: Years **67** Months **2** Days **28** If less than one day **hr. min.**

9. Birthplace **St. Louis Mo. 0**
(City, town, or county) (State or foreign country)

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

Major findings: Of operations _____

Of autopsy **as above**

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Hammer**

13. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant **T. G. Shipley**

(b) Address **5921a Coronado**

17. (a) **Burial** (b) Date thereof **May 16, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sunset Burial Park**

18. (a) Signature of funeral director **Wacker-Baldorfe**

(b) Address **3634 Gravois**

19. (a) **MAY 16 1944** (b) **J. F. Medel**
(Date received local registrar) (Registrar's signature)

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? **0** (Specify type of place) (e) Means of injury _____

23. Signature **Wacker-Baldorfe** (M. D. or other) **Wacker**
Address **Wacker-Baldorfe** Date signed **5/15/44**

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

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 Robert Wheeler

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.