

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23528

State File No. _____
Registrar's No. **6645**

Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County **ST LOUIS, MO.**
(b) City or town _____
(c) Name of hospital or institution: **1722 CORA. AVE**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **4 years.** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **St Louis**
(c) City or town **ST LOUIS** (If outside city or town limits, write "RURAL")
(d) Street No. **1722 CORA. AVE** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **ANNIE WAPLES**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Female** 5. Color or race **Col** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive **DEAD** years (Day) (Year) **1877**

8. AGE: Years **67** Months **3** Days **7** If less than one day _____ hr. _____ min.

9. Birthplace **New Orleans** (City, town, or county) (State or foreign country)

10. Usual occupation **House Wife**

11. Industry or business _____

MOTHER FATHER { 12. Name **George M. Shannon**
13. Birthplace **Unknown** (City, town, or county) (State or foreign country)
14. Maiden name **MATY MITCHELL**
15. Birthplace **New Orleans** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. M. K. Smith**
(b) Address **1722 CORA. AVE**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **July 29-44** (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park Cemetery**

18. (a) Signature of funeral director **James Smith**
(b) Address **4474 LA BARDIE AVE**

19. (a) **JUL 28 1944** (Date received local registrar) **J. J. French** (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **7** day **26** year **1944** hour **9** minute **30 P.**
21. I hereby certify that I attended the deceased from **1/21** 19**44** to **7/26** 19**44**; that I last saw him alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: **Sarcoma of Right Ovary**
Due to **metastases to lungs and spine**
Other conditions: _____ (Include pregnancy within month of death)
Major findings: _____
Of operations: _____
Of autopsy: **NO**

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 _____
(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 **J. J. French** (M. D. or other) _____
Address **St. Louis, Mo.** Date signed _____

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.....

William C. McDowell....., Registered Apprentice No.....
working under my personal supervision.

Signed *William C. McDowell*

Licensed Embalmer No. *2114*

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.