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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

FILED AUG 21 1944

818

Primary Registration-District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County.....  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Homer Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 days  
(Specify whether  
In this community 25 years  
years, months or days)

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. 1528 N. 16th St.  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME

Mary Shaw

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

4. Sex Female 5. Color or race 3 Colored 6. (a) Single, widowed, married, divorced 2 Widower

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

7. Birth date of deceased July 1, 1863  
(Month) (Day) (Year)

8. AGE: Years 81 Months 1 Days 2 If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name Charlie Rhodes

13. Birthplace Tenn.  
(City, town, or county) (State or foreign country)

14. Maiden name Polly McHenry

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

16. (a) Informant Shirley M. Smith

(b) Address 2601 N. Whittier St.

17. (a) Anatomical (b) Date thereof 8-9-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address 2715 Franklin St.

19. (a) Aug 9 (b) J. F. Bradeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 3,  
year 1944 hour 2 minute 35 A. M.

21. I hereby certify that I attended the deceased from July 19,  
1944, to August 3, 19 44  
that I last saw her alive on August 3, 19 44  
and that death occurred on the date and hour stated above.

Immediate cause of death Malignancy of Gall-bladder Duration Unk.

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?.....

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

23. Signature Shirley M. Smith (M. D. or other).....

Address 2601 N. Whittier St. Date signed 8/9/44

Received from Anatomical Board (License of Embalmer's Statement on Reverse Side) 8-9-44

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

MOTHER FATHER

**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.**